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**‘These are all my countries’- Exploring the psychosocial experiences of
refugee children and families resettling in Edinburgh.**

A systematic review of cultural adaptations to psychosocial interventions for families with
refugee/asylum-seeker status and an exploratory study examining the psychosocial
experiences of resettlement across refugee young people, families and organisations
supporting these families.

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Lay Thesis Summary

The first part of this project is a review of studies which evaluated psychological treatments conducted in the United Kingdom. These treatments had made adaptations to be culturally sensitive to refugee young people and families. Examples of adaptations include using interpreters, using art and storytelling, and training staff to be aware of cultural differences such as clothing, gender roles and religious beliefs. It is suggested that some of these cultural adaptations could make treatments more effective to refugee/asylum seeker families, compared to treatment as normal. The researcher looked for studies that gave support to refugee young people below 18 years old and refugee families. Eleven studies were included and results showed that young people and families found the cultural adaptations helpful. Treatments were effective for most young people, but many studies didn't compare their adapted treatment to 'normal' treatment. This means that the researcher cannot be certain which parts of the treatment made it effective. More research needs to be done to check out which adaptations might work best for refugee young people and families.

The second part of this project was to speak to refugee young people and refugee families about how it felt to resettle in Edinburgh. Staff who have supported refugees to resettle were also asked to speak about their experiences working with refugee families. Integration covers many different parts of daily life including, language, making friends, education, jobs and having a safe place to live. There is a risk that refugees and asylum seekers might experience mental health issues as a result of difficult memories of their past and problems with integration in Scotland. The researcher completed interviews with young people, a group of mothers and several groups of staff from NHS services or charities. Young people and mothers spoke of missing home and their families and felt that their identity had changed as a result of resettlement. Families had difficulties with integration because of language, racism and housing problems. Staff said that it was hard to support refugee families because they did not have much information on how to help and they were not given guidelines. They also felt that they were put in a difficult position between helping refugee families and immigration laws. From these interviews, there were a number of recommendations for Scottish services such as putting more effort into engaging with refugee families, improved and consistent interpreter systems, training for staff and more links between NHS teams and charities.

Portfolio Abstract

Objective: The systematic review aimed to evaluate the effectiveness of cultural adaptations to psychosocial interventions conducted within the United Kingdom. The empirical study aimed to explore the psychosocial experiences of young refugees and their families resettling in Edinburgh. Additionally, it sought to gather information on the experiences of staff and volunteers from organisations working with refugee/ asylum-seeking families. A triangulation of these three groups aimed to provide rich insight into the resettlement process and provide opportunities for meaningful change.

Methods: For the review, eleven databases were searched to identify studies examining psychosocial interventions for refugee young people and families. Cultural adaptations were also identified within these studies to examine their effectiveness at supporting refugee families. For the empirical study, interviews and focus groups were conducted across the three participant groups; refugee young people, refugee mothers and staff members. Refugee participants were asked questions about the positive and negative aspects of resettling in Edinburgh, whilst staff participants discussed the rewards and challenges when working with refugee populations.

Results: For the systematic review, eleven studies met eligibility criteria. These studies used a number of methodological designs, psychosocial interventions and cultural adaptations to engage and support refugee families. The identified studies reported that participants found the culturally adapted interventions helpful. During the empirical study, four themes emerged across all three participant groups; *Trust & Safety*, *Connection & Disconnect*, *Meeting Needs* and *Identity*. Three other themes emerged specific to different participant groups; *Loss & Longing* for both refugee groups, and *Unknown & Uncertainty* and *Vocational Discord* for the staff participant group.

Discussion: Studies in the systematic review have provided support for the use of cultural adaptations, however there were no measures taken to identify the effectiveness of different components of treatment. The empirical study identified clinical implications and recommendations for service change. Both parts of this project emphasise the need for further research within a refugee/ asylum-seeker population, with particular emphasis on building trusting relationships and recognising cultural strengths and coping strategies.

Glossary of Abbreviations

ADHD- Attention Deficit Hyperactivity Disorder

CAI- Culturally Adapted Intervention

CAMHS- Child and Adolescent Mental Health Services

CBT- Cognitive Behavioural Therapy

CEO- Chief Executive Officer

IPT- Interpersonal Therapy

NGO- Non-profit organisation, independent of the government

PTSD- Post Traumatic Stress Disorder

R/AS- Refugee or Asylum Seeker status

VPR Scheme- Vulnerable Person's Resettlement Scheme

For the purpose of this study, the researcher will refer to people with refugee or asylum seeker status interchangeably, as asylum-seekers are people who have yet to receive a Home Office answer on their refugee status.

Abstract

Objective: Culturally adapted interventions (CAI) for young people aim to provide a culturally-sensitive approach to mental health support for children and adolescents experiencing difficult symptoms. A systematic review was conducted to determine the different types of cultural adaptation in the included studies, and to determine the efficacy of CAI's in comparison to generic treatment.

Methods: Systematic searches of eleven databases (PsycINFO, MEDLINE, ASSIA, PubMed, SCOPUS, Web of Science, CABI, IBSS, Knowledge Network, OpenGrey and Google Scholar (15 pages) were completed in May 2020. Any psychosocial interventions aimed at providing mental health support for refugee young people and families were included. This was to ensure the inclusion of studies which may not fit the traditional Western framework of assessment and intervention.

Results: Eleven studies of varying methodology, participant group, intervention type and outcome measures were included in this review. Studies used a variety of cultural adaptations including surface-level and deep-level adaptations. All studies showed support for the use of CAIs with young people, with varying degrees of symptom reduction. It was not possible to compare the effectiveness of CAIs against treatment-as-usual, nor to determine the effectiveness of different CAI components.

Conclusions: Whilst there is evidence for the use of CAIs with R/AS young people, the heterogeneity between studies limits the generalisability of these results. The available research is not sufficient to provide conclusive evidence of the use of CAIs over treatment-as-usual. Research and clinical implications are highlighted. Future research could examine the most effective components of CAIs and aim to increase the evidence base of interventions for young people and families with R/AS.

Introduction

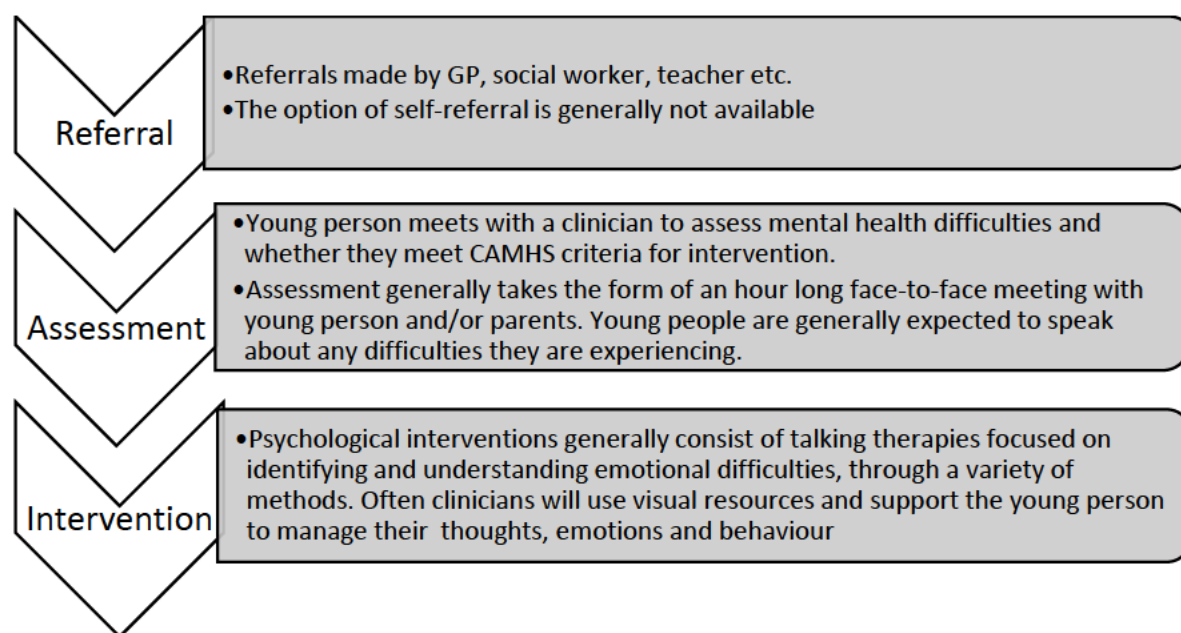
Displacement of individuals due to persecution and war has caused rising numbers of asylum appeals for the United Kingdom, from 8,197 applications in 2012 to 32,693 in 2019 (Home Office, 2019). Due to the United Kingdom's pledge to accept up to 20,000 (Syrian) refugees by year 2020, there has been an increasing influx of refugee individuals, particularly in Scotland (40% of pledged UK refugees: Scottish Refugee Council, 2017). Refugees and asylum- seekers (R/AS), as recognised in the 1951 United Nations Refugee Convention (UN General Assembly, 1951), are individuals and their dependents who seek asylum within a country not of his/her nationality, due to a fear of persecution in his/her own country. This persecution may originate from religion, nationality, race or political opinions. It is estimated that approximately half of all R/AS are children and adolescents under the age of 18 (UNHCR, 2004). When refugees first settle in a country, physiological and safety needs such as housing, employment and transition to a new culture often take priority over other considerations such as mental health (Maslow, 1943; Mind, 2009). However, young people with R/AS have often experienced multiple traumas, missed a significant amount of education and are at risk of developing significant mental health difficulties (Fazel & Stein, 2002; Mind 2009; Murray, Davidson & Schweitzer, 2010). Assimilation to a new country and culture, whilst dealing with the traumatic events that required initial displacement may contribute to significant distress (Derluyn & Broekaert, 2007). This distress can present as challenging behaviour, neurodevelopmental delays or more common psychopathologies such as PTSD or anxiety (Bath, 2008; Fazel, Reed, Panter-Brick & Stein, 2012; Fazel & Stein, 2003).

The context in which mental health is viewed influences policies and government strategies, therefore dictating how care is delivered to at-risk individuals (Singer, Bulled, Ostrach & Mendenhall, 2017). Traditional Western frameworks regarding mental health often view individuals and their direct environment as the main cause of mental health difficulties, possibly overlooking social, ecological and political contexts (Singer et al., 2017). The Mental Health Strategy for Scotland (2017-2027) aims to address issues of inequality to accessing services and of treatment provision for all. Key points surrounding the care of children and adolescents include access to mental health support in schools, evidence-based interventions for young people, reducing the incidence and impact of adverse childhood experiences (ACEs), and development of multi-agency, collaborative pathways to care (Scottish Government, 2017). By tackling these issues early, it is anticipated that services may be able to prevent long-term mental health difficulties, leading to more positive outcomes for the young person and less reliance upon services in the future (Beauchaine, 2017).

Unfortunately, there are concerns about the accessibility (and quality) of child and adolescent mental health services across the UK (CAMHS; Mind 2009). A number of systematic reviews suggest

that, often, the most vulnerable groups in society such as minority communities, those with complex histories face the most barriers and have the lowest rates of accessing CAMHS services (Radez et al., 2020; Anderson et al., 2017). Difficulties arise throughout the process of accessing and utilising mental health services, see Figure 1.

Figure 1: Simplified CAMHS Pathway



Research suggests that a number of factors could influence the presentation of mental health difficulties in different cultures, i.e. poor concentration, behavioural difficulties or psychosomatic symptoms, possibly resulting in signposting to inappropriate services (Rousseau et al., 2007; Rechtman, 2000). Even if young people are accepted to services, many refugee families can be reluctant to avail themselves of mental health services, for various reasons including unfamiliarity with services, worries about securing asylum status and religious beliefs (Ali, McLachlan, Kanwar & Randhawa, 2017; Hodes, 2000). Young people with R/AS often originate from countries where mental health services are virtually non-existent (Hughes, 2014). Other complicating factors include the stigma of mental health difficulties within their native communities (Thomson, Chaze, George & Guruge, 2015), distrust of authorities (Hek, 2005) and practical barriers such as transport or language issues (Brown, Rice, Rickwood & Parker, 2016; Ali et al., 2017). Parents also identified issues with recognising difficulties and lacking confidence in professionals (Reardon et al., 2017). In fact, research from Holland, suggested that although 58% of unaccompanied minors experience psychological distress, only 13% access mental health services (Bean et al., 2006; Said & King, 2019). Anderson et al. (2017) suggested service improvements could be made in a number of areas, including walk-in clinics, accessible locations e.g. GP or schools, culturally appropriate services and

telephone check-ins whilst on the waiting list. Research into mental health care suggests that young people with R/AS may be more likely to use charities or third-party organisations to promote wellbeing (Scottish Refugee Council 2017). Within the UK, charities may have more resource to provide flexible outreach services, community projects and provide wellbeing through less traditional approaches to mental health, e.g. sports, music, youth groups (Scottish Refugee Council 2017).

Collaborative care and a holistic approach to mental health support has been suggested to improve outcomes for minority young people, by allowing multiple professional disciplines to come together and address all issues facing a young person (Rousseau, Measham & Nadeau, 2013). However, this approach may bring up additional complications, i.e. some families with R/AS have voiced concern about confidentiality regarding their details being passed to multiple professional disciplines, especially within the ongoing asylum processes (Nadeau, Jaimes, Johnson-Lafleur & Rousseau, 2017). Young people who do accept referrals to public mental health services may experience teams with limited knowledge of specific unmet needs and cultural sensitivity, leading to feelings of inadequacy from staff and poorer outcomes for the child (Mind, 2009). The majority of mental health research has been conducted in Western countries on native populations, often with strict criteria excluding non-English speakers, neuro-diverse individuals and ethnic minorities (Cardemil, 2010). It is therefore unsurprising that many of the empirically supported interventions may not be generalizable to those who do not fit into the Western constructs of mental health expression and therefore pathways for services (Shiraeve & Levy, 2016; Schweitzer, Robert & Steel, 2008). Similarly, psychometric measures used to assess mental health and treatment outcomes, may not be cross-culturally valid (Kaiser et al., 2019; Rüdell, Bhui & Priebe, 2009). One approach to addressing these limitations is the use of culturally adapted interventions.

Culturally Adapted Interventions (CAI)

Cultural adaptation is defined as the methodological modification of an intervention to consider unique aspects of a client's needs, including language, culture and values (Bernal, Jiménez-Chafey & Rodríguez, 2009). Researchers have described two categories of cultural adaptation to interventions; surface structure and deep structure components (Cardemil, 2010; Barrera, Castro, Strycker & Toobert, 2013). Surface structure adaptations represent small modifications to the content and delivery of an intervention, such as changing ethnicity of cartoons or location of intervention (Castro, Barrera & Martinez, 2004; Cardemil, 2010; Thompson et al., 2015). On the other hand, deep structure adaptations describe more careful considerations to an intervention, related to specific cultural needs; this might include incorporating cultural values, changes in programme content or the involvement of family and social network (Barrera et al., 2013; Mier, Ory & Medina, 2010).

Further categorisation of cultural adaptations includes peripheral, evidential, linguistic, socio-cultural and constituent-involving categories, see Table 1 (Kreuter et al., 2003).

Table 1: Categories of Cultural Adaptation (recreated from Barrera et al., 2013)

Strategies		Description
Surface	Linguistic	Ensure that intervention materials are available in a young person's preferred language and at the literacy level of clients
	Evidential	Use narratives and statistics relevant to the target group and raise awareness of difficulty within specific culture
	Peripheral	Use of activities, photographs and titles to relate to the clients own ethnicity, cultural norms and environment, e.g. music, dancing, photos of females wearing headscarves etc.
Deep	Socio-cultural	Using a community's culture to explain difficulties within a context which is familiar and understood e.g. using food, stories, religion, collectivism etc.
	Constituent-Involving	Training and using members of the target population to increase engagement from community, by increasing approachability and knowledge of community health beliefs

Despite growing calls to develop psychological interventions inclusive of ethnic minorities and young people with R/AS, research has been slow to accrue and existing studies have struggled with difficulties of sample size and categorisation of cultural adaptations. Griner and Smith (2006) conducted a comprehensive meta-analysis of 76 studies exploring the efficacy of CAIs, and found a medium effect size ($d = 0.45$) for CAI's with an increased effect when the intervention was available in the client's preferred language. They argued the necessity of including studies even with heterogeneous comparison treatment types and poor quality studies, despite limiting the generalisability of results. Huey and Polo (2008) found similar levels of efficacy of CAIs when compared to no treatment ($d = 0.58$), despite stricter inclusion criteria. More recently, Benish, Quintana and Wampold (2011) conducted a review of studies exploring client outcomes in CAI's compared to 'bona-fide' treatments and significantly supported the use of CAI over conventional treatment for targeted populations ($d = 0.32$). They reported that this difference was moderated by cultural adaptations of illness myth, described as a shared understanding of difficulties within the context of client's cultural values. With regards to specific child and adolescent interventions, randomised control trials produced statistically significant improvements using culturally adapted CBT and IPT interventions compared to waitlist conditions (Rosselló & Bernal, 1999; Rosselló, Bernal & Rivera-Medina, 2008). Interventions such as culturally adapted groups, evidence based

interventions and specialist novel services for young people with R/AS have all supported the use of adapted treatment components (Nocon, Eberle-Sejari, Unterhitzberger & Rosner, 2017; Miranda et al., 2005; Jackson-Blott et al., 2015; Colucci et al., 2017).

Of importance, others (Huey & Polo, 2008) have found limited support for cultural adaptations; as results showed no significant outcome differences between several CAI and standard treatment for minority young people across a number of mental health difficulties. However these conclusions must be taken with caution as several of the reviewed studies lacked sufficient power and assessment was not conducted on the content or quality of the cultural adaptation. Considerations must be made regarding the importance of untested cultural adaptations if they may compromise components of effective interventions (Lau, 2006). Additionally, it may be that clinicians are already adjusting their treatment to the cultural needs of their young people, without documenting it in the research literature (Huey & Polo, 2010; Harper & Iwamasa, 2000), therefore confounding the comparisons between CAIs and standard treatment. Some programmes such as Incredible Years has shown adaptability to various cultural groups, without needing formal alterations to content or delivery (Reid, Webster-Stratton, & Beauchaine, 2001; Webster-Stratton, 1998). However few interventions have deliberately included sufficient participants from multiple cultures within their evaluation of efficacy (Cardemils, 2010).

Overall, there appears to be some support for the use of CAI for young people with R/AS, with emphasis on linguistic and socio-cultural strategies (Griner & Smith 2006; Cardemils, 2010). Some research suggests that there may be little difference in participant outcomes when compared with standard treatment, however these studies were often underpowered or minimal cultural adjustments made (Huey & Polo, 2008; Barrera et al., 2013). Unfortunately, due to time, cost and sample size restraints, it may be difficult for researchers to directly assess whether the culturally adapted features increase the efficacy of an intervention compared to standard treatment.

Rationale

The need for effective psychological interventions for young people with R/AS is highlighted by their elevated risk for developing mental health difficulties. The multiple barriers they face in accessing mental health services and the limited research base, regarding their unique needs, explains their experience of mental health services. There is some evidence to support cultural adaptations to mental health interventions in host countries for young people with R/AS, however this is sparse. Additionally there is a question regarding the applicability of findings from various countries, (e.g. USA or Canada), to a UK setting, both in terms of unique host country, but also within a public health system with limited resources to create and manage specialist services.

This systematic review aims to collate information from various studies conducted in the UK. It will explore the effectiveness of cultural adaptations to psychological interventions for young people with R/AS. The combining of study results can provide more power than a single study (Sterne, Egger & Smith, 2001), and to the researcher's knowledge, this will be the first review of such studies.

Aims

Explore the effectiveness of culturally adapted mental health interventions for young people and families with R/AS, in the UK, and evaluate their experiences of participating in such interventions.

Methods

This review is in adherence with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA; Moher et al., 2009). As per guidelines, this protocol has been registered through PROSPERO (ID: CRD42020138553).

Eligibility Criteria

To ensure that all study and intervention types were included within this review, broad eligibility criteria were applied;

- Location: Conducted within United Kingdom (within public or private services)
- Participants: Young people (below 18 years old) or families with R/AS
- Intervention: Any adapted psychosocial intervention intended to improve mental health or emotional wellbeing. The inclusion of traditional evidence-based and/or alternative interventions allows the evaluation of treatments which may not strictly adhere to a Western construct of therapy
- Outcomes: Guided by Harden et al, (2010; see Appendix B), this systematic review examined quantitative data such as comparisons of pre- and post- intervention questionnaire scores and qualitative information such as interview data
- English Language

The combination of study designs in systematic reviews are increasingly required to provide sufficient evidence for clinical, organisational and policy decisions (Lizarondo et al., 2017; Peinemann, Tushabe & Kleijnen, 2013), therefore there were no limitations on study design. This was considered especially important given the already limited research base on mental health in young people with R/AS.

Search Strategy

Searches of eleven online scientific databases were conducted (PsycINFO, MEDLINE, ASSIA, PubMed, SCOPUS, Web of Science, CABI (Global Health), IBSS, the Knowledge Network, OpenGrey and Google Scholar (15 pages). The search aimed to identify both published and unpublished studies conducted between 1950 and 31st May 2020, (see Table 2 for key terms). Snowballing techniques included reference list searches and contacting various authors for any relevant or unpublished data.

Details of eligible studies were extracted, including author(s), study design, intervention type, outcome measures, results and any other points of interest (see Table 5).

Table 2: Search Terms

"refuge*" OR "immigra*" OR "migra*" OR "asylum*" OR "illegal*" OR "unaccompanied minor*" OR "displac*" OR ----- AND ----- "mental*" OR "mental health" OR "psycholo*" OR "psychiatr*" OR "emotion*" OR "wellbeing*" OR "distress*" OR "stress*" OR "mood*" OR "trauma*"
----- AND ----- "intervene*" OR "treat*" OR "therap*" OR "program*" OR "group*" OR "support*"
----- AND ----- "CAMHS" OR "child*" OR "adolescen*" OR "young pe*" OR "young*" OR "famil*" OR "parent*" OR "carer*" OR "caregiver*" OR "teenage*" OR "infant*" OR "Mum*" OR "Dad*" OR "mother*" OR "father*" OR "minor*"
----- AND ----- "culturally sensitive*" OR "culturally enhance*" OR "culturally appropri*" OR "culturally inform*" OR "culturally ground*" OR "culture specific*" OR "culturally focus*" OR "cultur*" OR "adapt*" OR "ethnic*"

Quality Assessment

The included studies were quality assessed using guidelines by Kmet, Cook and Lee (2004; see Appendix C) who designed criteria for assessing both quantitative and qualitative studies. This allowed for parallel evaluation of the various methodologies and has been used effectively in similar reviews (Reardon et al., 2017; Barnett et al., 2019). Items on both checklists use three point scales for determining adherence to item criteria (0 –no, 1- partial, 2- yes). The maximum score on the quantitative list is 28, whilst the qualitative list adds up to 20. Two independent reviewers completed separate quality assessments; results were compared and any discrepancies were resolved by discussion. A Cohen’s Kappa test was used to assess inter-rater reliability (0.81) and suggested good agreement between reviewers (Viera & Garrett, 2005). Table 3 indicates the scores of each study, based on their compliance to each item on the quality assessment. For the purpose of this review, scores have then been represented as a percentage for easier comparison over both study types. Studies were found a score of ≥54% on all studies indicating varied adherence to recommended guidelines (See Table 3).

Table 3: Quality Assessment of Included Studies

	King & Said (2019)	Dura-Vila et al. (2012)	Said & King (2019)	Ehnholt et al. (2005)	Fazel et al. (2009)	O'Shea et al. (2000)	O'Shaughnessy et al. (2012)	Fazel et al. (2016)	Vickers (2005)	Hughes (2014)	Chiumento et al. (2011)
All Studies											
Objective Described	1	2	2	1	2	1	2	2	2	1	1
Design appropriate to objective	0	2	2	2	2	1	2	2	1	2	2
Results support conclusions	2	2	2	2	2	2	2	2	2	2	2
Quantitative Assessment											
Method of subject selection appropriate	1	2	1	1	2	1					
Subject characteristics and variables described	2	2	2	1	1	2					
Random allocation to treatment/ control group	N/A	N/A	N/A	0	N/A	0					
Blinding of investigators to intervention type	N/A	N/A	N/A	N/A	N/A	0					
Blinding of participants to intervention type	N/A	N/A	N/A	N/A	N/A	N/A					
Outcome and exposure measures defined	1	2	2	2	1	1					
Suitable sample size	1	2	0	1	2	1					
Analysis appropriate	2	2	1	2	2	2					
Estimate of variance reported	2	1	0	2	2	1					
Controlled for confounding	N/A	N/A	0	0	2	0					
Results reported	1	2	1	2	1	2					
Qualitative Assessment											
Context of study is clear							2	2	2	2	2
Connection to theoretical framework							2	2	2	2	0
Sampling strategy relevant							1	2	1	0	1
Data collection methods systemic							1	2	0	0	2
Data analysis described, complete and systemic							2	1	0	0	1
Use of verification procedures							0	2	0	0	0
Reflexivity of account							1	0	1	2	2
Total Score (Percentage)	14 (70%)	21 (95%)	13 (59%)	16 (67%)	19 (86%)	14 (54%)	15 (75%)	17 (85%)	11 (55%)	11 (55%)	13 (65%)

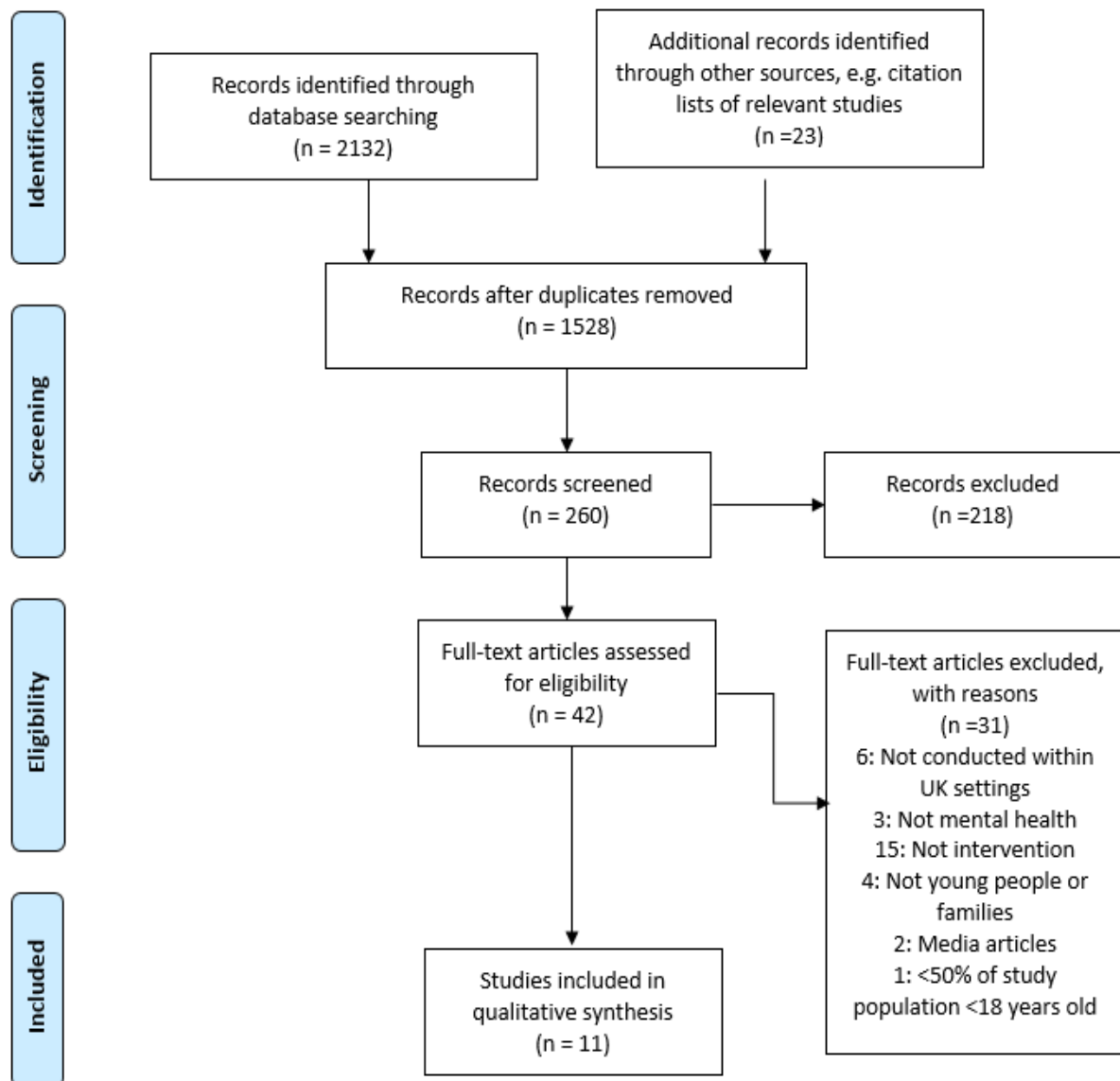
*0 –no compliance to criteria, 1- partial compliance, 2- full compliance

Results

Study Selection

Figure 2 outlines the procedure for the identification and screening of studies conducted between 30th September 2019 and 31st May 2020. The literature search yielded a total of 1528 studies, which reduced after Abstract screening and a further 31 papers were omitted after full-text review. The reasons for exclusion after full-text review are listed in Figure 2. Eleven studies met final eligibility criteria and were quality assessed.

Figure 2: PRISMA Flow Diagram of Search



Participant Characteristics

The sample size per study ranged from 2 to 141 with a combined participant number of approximately 420, (103 female, 215 male and 102 unknown). There were both child (estimated 398) and parent participants (22), although this number does not encompass parents included as indirect members of their child's therapy. One study (Hughes, 2014) did not report the number of young people participants and the researcher was unable to confirm through author correspondence. Participants reported a number of origin countries including Afghanistan, Albania, Congo, Ethiopia, Gambia, Horn of Africa, Iran, Iraq, Ivory Coast, Kosovo, Nigeria, Sierra Leone, Somalia, Sudan and Turkey.

Mental Health Characteristics

Specific mental health difficulties were identified in less than half of the included studies. Case studies described young people presenting as sad, withdrawn, unsettled friendships, nightmares and flashbacks, (Vickers, 2005; Dura-Vila et al., 2012). Teachers reported seeing symptoms of PTSD, aggressive behaviour, adjustment disorder and conduct disorder (O'Shea et al., 2000; Entholt et al., 2005). Three studies noted the presentation of difficulties in schools could have been considered under the diagnosis of ADHD, including hyperactivity and inability to concentrate (O'Shea et al., 2000; Said & King, 2019; Dura-Vila et al., 2012). Other studies targeted the general mental health needs of the R/AS population through the use of specialist R/AS services or to evaluate the feasibility of easy-access locations, e.g. schools (O'Shaughnessy et al., 2012; Fazel et al., 2009; Said & King, 2019; Chiumento et al., 2011; King & Said 2019). The mental health of mothers was the focus of two studies (Hughes, 2014; O'Shaughnessy et al., 2012), with the premise that this had an effect on their child's attachment relationships, emotional well-being and behaviour. Mothers described feelings of depression, loneliness, family relationship difficulties and trouble adjusting to life in the UK (Hughes, 2014).

In addition to evaluating mental health difficulties pre- and post-intervention, several studies collected demographic information about traumatic experiences and exposure to conflict (Entholt, Smith & Yuke, 2005; Said & King, 2019, O'Shea et al., 2000). Entholt et al. (2005) used the War Trauma Questionnaire (WTQ; Macksoud, 1993) and found the young people had experience separation from parents (44%), threats towards loved ones (89%) witnessed and/or experienced violence (82%) and had lost a loved one (56%). On average, young people had experienced 16.5 of the 32 war trauma experiences in the WTQ, and the majority of young people met clinical criteria for PTSD and depression. Said & King (2019) reported participants had experienced events including physical and sexual assault, trafficking and war torture. Interviews were used to determine child and

family exposure to war and violence (O'Shea et al., 2000), including several country moves (50%), imprisonment (14%), relatives killed (73%) and difficulties with the asylum process (49%).

Study Methodologies

Studies used a variety of study designs including qualitative (3/11), case control (2/11) and mixed methods (5/11) and 1 case study. Both case controls (Fazel et al., 2009; Entholt et al., 2005) used matched control groups; Fazel et al. (2009) matched on age and gender whilst Entholt et al. (2005) matched groups on gender, country of origin and legal status. There were no randomisation or blinding methods used in either study. O'Shea et al. (2000) and Dura-Vila et al. (2012) used the same clinical vignettes (some details changed) to illustrate the type of symptoms and interventions used within their studies. Five studies reported the discipline of the clinicians including clinical psychology trainees (Said & King, 2019; Entholt et al., 2005; King & Said, 2019), psychiatry trainees (Fazel et al., 2009; Dura-Vila et al., 2012) and nurses (Fazel et al., 2009).

Intervention Characteristics

The majority of studies evaluated the effectiveness of evidence-based therapies, including cultural adaptations to cognitive behavioural therapy (CBT; King & Said, 2019; Entholt et al., 2005), 'Tree of Life' narratives (Hughes, 2014) and narrative therapy, (Said & King, 2019) whilst others explored the feasibility of specialist refugee/ asylum-seeker services such as the Haven Project (Chiumento et al., 2011; Dura-Vila et al., 2012; Fazel et al., 2009; Fazel et al., 2016; O'Shea et al., 2000). Chiumento et al. (2011) described a range of group interventions available to young people with R/AS within their specialist service; art therapy, psychodrama and horticulture. The results of only two intervention groups were reported in their paper and attempted author correspondence did not provide additional information.

Some studies provided multiple format options for intervention including structured or unstructured group sessions (Chiumento et al., 2011; King & Said, 2019; Entholt et al., 2005) individual sessions (Fazel et al., 2016; Said & King, 2019) and systemic work with families or schools (Vickers, 2005). Many studies reported family involvement, however others evaluated direct support provided to mothers. O' Shaughnessy et al. (2012) described an intervention for infant mental health, which offered general practical and social support to new mothers with R/AS, aiming to improve the attachment relationship between mother and baby.

Of those who specified, treatment ranged from 6 weeks to 37 weeks (Said & King, 2019; Fazel et al., 2016; Hughes, 2014), however others did not provide this information (Dura-Vila et al., 2012; Fazel

et al., 2009). Others reported that interventions took the format of weekly or fortnightly appointments until the young people deemed themselves able to continue without support (Said & King, 2019; Chiumento et al., 2011).

Cultural Adaptations

Researchers typically provided descriptions of the adaptations to the interventions in their studies, however there were no efforts taken to measure the extent and quality of such adaptations. There were commonalities between the studies as to the cultural adaptations made to evidence-based interventions, see Table 4. As categorised by Barrera et al. (2013), many studies implemented *linguistic strategies* such as use of interpreters or translated written materials, and *socio-cultural strategies* including sensitivities towards cultural values. Only two reviewed studies used *constituent-involving strategies* (O'Shaughnessy et al., 2012; Hughes, 2014), who provided specialist training for community workers and used R/AS community workers, respectively. Several studies emphasised location of intervention as a key factor in delivering support to young people with R/AS, in particular, school settings (O'Shea et al., 2000; Fazel et al., 2009).

Table 4: Cultural Considerations and Adaptations, as categorised by Kreuter et al. (2003); Barrera et al. (2013)

Strategies	Examples	Studies (N)
Linguistic	<ul style="list-style-type: none"> Bilingual and bicultural materials Use of interpreters Consideration of developmental & literacy level 	King & Said 2019; O'Shaughnessy et al, 2012; Dura-Vila et al, 2012; O'Shea et al, 2000; Fazel, Garcia & Stein, 2016; Vickers, 2005; Said & King, 2019; Hughes, 2014 (8 studies)
Constituent-Involving	<ul style="list-style-type: none"> Bilingual and bicultural staff Specialist training for native community health workers Workers employed from native community 	O'Shaughnessy et al, 2012; Hughes, 2014 (2 studies)
Peripheral	<ul style="list-style-type: none"> Inclusion of culturally familiar activities, e.g. music, games or food Role models from native ethnic background 	O'Shaughnessy et al, 2012; Chiumento et al, 2011; Hughes, 2014 (3 studies)
Socio-cultural	<ul style="list-style-type: none"> Inclusion of cultural values in intervention design or implementation, e.g. religion (fasting during Ramadan) or familism Intervention content targeted to specific cultural difficulties, e.g. asylum legal process, education on host country social norms etc. Use of culturally specific symbols 	King & Said 2019; O'Shaughnessy et al, 2012; O'Shea et al, 2000; Fazel, Garcia & Stein, 2016; Vickers, 2005; Said & King, 2019; Chiumento et al, 2011; Hughes, 2014 (8 studies)
Evidential	<ul style="list-style-type: none"> Acknowledgement of loss, family difficulties and vulnerable narratives Use of trauma or war specific questionnaires Focus on unaccompanied minor health, prevalence of traumatic experiences 	King & Said 2019; O'Shea et al, 2000; Dura-Vila et al, 2012; Ehntholt et al, 2005; Said & King 2019; Chiumento et al, 2011; Hughes, 2014 (7 studies)
Other	<ul style="list-style-type: none"> Delivery of intervention in group setting Delivery of intervention in safe location, familiar to participant, e.g. school or mosque Provision of hands-on activities Involvement of family in intervention Use of social support and networks Sensitivity to staff lack of knowledge Sensitivity to mental health stigma Culturally-specific outcome measures 	King & Said 2019; O'Shaughnessy et al, 2012; Dura-Vila et al, 2012; Ehntholt et al, 2005; O'Shea et al, 2000; Fazel, Garcia & Stein, 2016; Fazel, Doll & Stein, 2009; Chiumento et al, 2011; Vickers, 2005; Said & King 2019; Hughes, 2014 (11 studies)

Table 5: Reviewed Study Characteristics

<u>Study ID</u> <u>Quality Assessment</u>	<u>Design</u>	<u>Sample</u>	<u>Country of Origin</u> <u>& Status</u>	<u>Targeted Domain</u>	<u>Study Summary</u>
King & Said (2019) 70%	Mixed Methods	14 participants Mean Age: 16 1 female & 13 male	5 Afghanistan, 3 Ethiopia, 5 Sudan, 1 Somalia (all unaccompanied asylum-seeker)	No symptoms specified: General R/AS wellbeing	<ul style="list-style-type: none"> Effectiveness of a CBT group for unaccompanied minors with R/AS (adaptations include use of interpreters within group setting, sensitivity of language stigma, focus on transitions & resettlement, racism, developmental needs, religious sensitivity, focus on physical health). Outcome Measures: Strengths & Difficulties Questionnaire (SDQ; Goodman et al, 1994), Reliable Change Index, (Jacobson & Truax, 1991), Child Revised Impact Events Scale (CRIES; Perrin et al, 2005), focus group Half of participants showed reliable improvement on SDQ whilst a third of participants showed improvement on CRIES. Identified themes included helpfulness of group, feeling welcome & safe, peer support, increased wellbeing strategies.
O'Shaughnessy, Nelki, Chiumento, Hassan & Rahman (2012) 75%	Qualitative	13 dyads (mother & infant) Mother Age Range: 17-32	Gambia, Sierra Leone, Ivory Coast & Nigeria (all asylum-seeker)	No symptoms specified: General R/AS mother and infant wellbeing	<ul style="list-style-type: none"> Mental health group intervention for mothers and babies <1 year old, with aim of increasing secure attachment opportunities (adaptations include cross-culturally trained facilitators, outreach services, visual aids, culturally appropriate food, sensitivity to parenting beliefs and increased social support). Outcome Measures: Infant CARE- Index (Crittenden, 2007), session by session Likert scale and reflective focus groups Mothers reported improvements in mood, understanding of their child's needs using session by session questionnaires. Results for Infant CARE Index showed improvement for 2 mothers, good enough for 1 mother and borderline for 2 mothers, regarding relationship quality. Identified themes included increased social support, feeling less alone, feeling safe, improved parenting knowledge, mother & baby relationships and untold narratives.
Vickers (2005) 55%	Case Study	2 participants 6 & 14 years old 1 female & 1 male	1 Africa, 1 Balkans (2 refugee)	PTSD	<ul style="list-style-type: none"> Case studies illustrating use of Ehlers & Clark (2000) model of Post-Traumatic Stress Disorder (adaptations included sensitivity to confidentiality, focus on trauma, resettlement and legal process, family work). Outcome Measures: Post Traumatic Diagnosis Scale (Foa, in Wilson & King, 1997) Both case studies showed descriptive support for the adapted use of Ehlers & Clark (2000).

Ehnholt, Smith & Yule (2005)	Case Control	26 participants (15 CBT group & 11 control group) Mean Age: 13 9 female & 17 male	11 Kosovo, 10 Sierra Leone, 3 Turkey, 1 Afghanistan, 1 Somalia (15 asylum-seeker, 2 refugee, 6 unaccompanied minor)	Teacher identified emotional & behavioural difficulties: PTSD, depression, anxiety	<ul style="list-style-type: none"> School-based 6 week manualised CBT group compared to control group (adaptations include focus on trauma and war experiences, school-setting, adapted outcome measure). Outcome Measures: 13-item Revised Impact of Events (R-IES, Smith et al, 2003), DSRS (Birleson, 1981), Revised Children's Manifest Anxiety Scale (Reynolds & Richmond, 1978), adapted WTQ (Macksoud, 1992), teacher SDQ (Goodman, 1994). Statistically significant differences on R-IES <i>total score</i> & <i>intrusion</i> subscale and SDQ <i>total score</i> & <i>emotional difficulties</i> subscale in the CBT group. There were no significant differences for control group outcome measures. Follow-up of 8 participants showed no statistically significant improvements
Dura-Vila, Klasen, Makatini, Rahimi & Hodes (2012)	Mixed Methods	102 participants Mean Age: 10 26 female & 76 male	45 Middle East, 27 Africa, 23 Europe, 7 other	No symptoms specified: General R/AS wellbeing	<ul style="list-style-type: none"> Exploration of 3 year community-based mental health intervention for young people with R/AS (individual therapy, problem-solving, multi-disciplinary working, family therapy) Adaptations include interpreters, school/ charity based, focus on loss, Outcome Measures: Strength & Difficulties Questionnaire for teachers and therapists (Goodman, 1994) Statistically improvement was seen in post-intervention scores in 75% of participants. Participants who had been living in the UK longer were most likely to have significantly improved
Fazel, Doll & Stein (2009)	Case control	141 participants (47 young people with R/AS, 47 ethnic minority controls, 47 indigenous controls) 30 female & 64 male, 47 unknown	R/AS group: 24 Balkans, 20 from Asia & India, 3 Africa	Teacher identified emotional & behavioural difficulties: anxiety, preoccupation, aggression	<ul style="list-style-type: none"> Evaluation of school-based intervention for young people with R/AS and two control groups (weekly teacher consultations, individual, family, group & indirect work, in-home & crisis intervention). Adaptations include school-based, multi-disciplinary liaison and staff support Outcome Measure: Teacher rated Strength & Difficulties Questionnaire (Goodman, 1994), custom closed and open ended questions. SDQ scores across all groups reduced significantly post-intervention, with particular improvement in the <i>hyperactivity</i> and <i>peer difficulties</i> subscales for R/AS young people Themes from teachers and young people explored helpfulness of service, limited resources for service provision and negatives of the service.

O'Shea, Hodes, Down & Bramley (2000)	Mixed Methods	14 participants Mean Age: 9.6 2 female & 12 male	9 Middle East, 3 Sub-Saharan Africa & 2 Europe (8 refugee & 4 asylum-seeker, 2 unknown)	Teacher identified emotional & behavioural difficulties: severe psychological difficulties, Stage 2 special education needs	<ul style="list-style-type: none"> Exploring a school-based mental health intervention (adaptations include location, tailored questionnaire, interpreters, systemic support, focus on loss, and support with legal processes). Outcome Measures: teacher rated Strength & Difficulties Questionnaire (Goodman 1994), Exposure to War & Violence Questionnaire (Espino, 1991). Case studies illustrated some descriptive improvement but no statistical comparisons reported.
Hughes (2014)	Qualitative	9 mothers, unspecified number of children	Mothers: Afghanistan Children: Congo, Horn of Africa, Afghanistan	No symptoms specified: General R/AS wellbeing	<ul style="list-style-type: none"> Strength-based, narrative 'Tree of Life' approach to support mothers to understand their history, mental well-being and managing children's 'difficult' behaviour. For young people to recognise mental health difficulties and develop strategies to manage adjustment to life in the UK Adaptations included practitioners from R/AS community, accessible and non-stigmatising location, focus on heritage, empowerment to write own narrative and visual supports Standard Western questionnaires were not used, verbal and written feedback encouraged instead. Mothers themes included sense of belonging, community, pride in culture and religion, peer support for parenting children. Child themes included pride in heritage, increased self-confidence, shared problem-solving and peer support
Fazel, Garcia & Stein (2016)	Qualitative	40 participants Mean Age: 17 11 female & 29 male	9 Europe, 13 Africa, 9 Iran/ Iraq/ Afghanistan, 7 Asia, 2 South America (29 asylum-seeker, 11 refugee, 13 unaccompanied minor)	No symptoms specified: General R/AS wellbeing	<ul style="list-style-type: none"> Evaluation of school-based mental health interventions for young people with R/AS (individual, family and group therapy). Adaptations included school-based, increased involvement of school & family, education on social norms, focus on asylum process. interpreters Semi-structured interviews explored using framework analysis. Themes identified included location of service, role of teachers, type of therapeutic intervention/ adaptations, asylum process and pre- & post-displacement stressors.

Said & King (2019) 59%	Mixed Method	4 participants Mean Age: 16.5 1 female & 3 male	2 Sudan, 1 Vietnam, 1 Albania (4 asylum-seeker)	PTSD	<ul style="list-style-type: none"> • Evaluation of Narrative Exposure Therapy for young people with R/AS (adaptations include use of interpreters, focus on trauma). • Outcome Measures: Child Revised Impact of Events Scale-8 item (Perrin, Meiser-Stedman & Stein, 2005), Child PTSD Symptom Scale for DSM-5 (Foa et al, 2018) and semi-structured interviews. • Reported reliable improvement for 3 participants (scores below clinical cut-off at post-intervention) • Themes identified included perceived benefits of engagement and challenging aspects of therapy
Chiumento, Nelki, Dutton & Hughes (2011) 65%	Mixed Method	42 participants (split across several groups)	-	No symptoms specified: General R/AS wellbeing	<ul style="list-style-type: none"> • Exploring the effectiveness of the Haven Project, a specialist refugee mental health service (adaptations included school-based, alternative therapies such as art therapy & horticulture, focus on loss and resettlement, groups). • Outcome Measures: Strength & Difficulties Questionnaire (Goodman 1994), interviews with participants. • Scores from questionnaires showed improvement in emotional well-being for many participants. • Themes included helpfulness of service, alternative therapies, confidence and peer support.

*Where information is not given, it has not been possible to collect this information from the publication or with author correspondence

Main Findings

Studies evaluated the interventions using a variety of methods including routine outcome measures, e.g. Strengths and Difficulties Questionnaire (SDQ; Goodman, 1997), focus groups or individual interviews (Fazel, Garcia & Stein, 2016) and case studies (O'Shea et al., 2000; Vickers, 2005; Dura-Vila et al., 2012).

Quantitative Outcomes

Quantitative studies used routine outcome measures to complete an evaluation of young people's mental health difficulties pre- and post-intervention.

- The Strengths and Difficulties Questionnaire (SDQ; Goodman, 1997) was used in five of the eight quantitative studies (Dura-Vila et al., 2012; Fazel et al., 2009; Ehnholt et al., 2005; King & Said, 2019; O'Shea et al., 2000)
- Child Revised Impacts of Events Scale (CRIES-8; Perrin, Meiser-Stedman & Smith, 2005; Said & King 2019; Ehnholt et al., 2005; King & Said, 2019)
- Child PTSD Symptom Scale (Foa et al., 2018; Said & King, 2019)
- Birelson Depression Self-Rating Scale (Birelson, 1981; Ehnholt et al., 2005)
- War Trauma Questionnaire (Macksoud, 1993; Ehnholt et al., 2005)
- Revised Children Manifest Anxiety Scale (Reynolds & Richmond, 1978; Ehnholt et al., 2005)
- Group Child Session Rating Scales (Duncan, Miller, Sparks & Murphy, 2011; King & Said, 2019)
- Clinical Rating Scale for Exposure to War & Violence (Espino, 1991; O'Shea et al., 2000)
- Infant CARE-Index (Crittenden, 2005; O' Shaughnessy et al., 2012)
- Post Traumatic Diagnosis Scale (Foa, Cashman, Jaycox & Perry, 1997; Vickers, 2005)

Due to the large heterogeneity between study designs, sample size, intervention type, and the lack of information available to calculate study effect sizes, a meta-analysis of quantitative data was not possible; results are instead described narratively.

Statistical tests were conducted by Ehnholt et al. (2005), Dura-Vila et al. (2012) and Fazel et al. (2009). Ehnholt et al. (2005) measured symptoms of depression, anxiety and PTSD in young people within the experimental and control groups, however only found statistically significant reductions in PTSD symptoms for the experimental group. Improvements in anxiety symptoms were not significant and there were no changes in depression symptoms for both groups. Participants in Fazel et al. (2009) reported significantly reduced symptoms of peer relationship and hyperactivity difficulties, however these improvements were modest. Dura-Vila et al. (2012) found a significant

difference in types of difficulties between recently resettled young people and those who had been living in the UK for more than two years. Peer problems were associated with a more recent arrival in the UK, whilst longer-term young people were reported to have conduct problems. There were also significant differences in the types of interventions used by young people; those settled more recently (<2years) were more likely to have indirect systemic work compared to longer-term young people who received significantly more direct individual sessions. Dura-Vila et al. (2012) reported significant overall improvements in approximately three quarters of participants, with particular symptom reduction in peer relations and hyperactivity.

Other studies were not able to conduct statistical analysis due to the small sample size and lack of power. Despite this, Said & King (2019) found that 3 of their 4 participants showed reliable improvement on the CRIES-8 (score change of >13), whilst the final participant did not have the opportunity to complete the intervention. O'Shea et al. (2000) found non-significant improvement in self-reported SDQ scores for young people who completed their school-based individual intervention; it was suggested that an additional 2 participants would have allowed sufficient power for statistical significance. O'Shaughnessy et al. (2012) used the Infant CARE-Index to analyse videos of mother-baby interactions from pre- and post- intervention with varying results. There was some improvement for three of the five tested dyads, however generalisability of these findings is tentative due to the small sample size. Case studies outlined by Vickers (2005) showed improvement for both young people, one case anecdotally and one case using scores on the Post Traumatic Diagnosis Scale, (Foa et al., 1997). More limited support was suggested by King and Said (2019) where half of participants showed reliable improvement on the SDQ and less than half showed reliable improvement on the CRIES-8.

Qualitative Outcomes

Table 6 displays the qualitative information collected from seven reviewed studies, through interviews (Said & King, 2019; Fazel et al., 2016), focus groups (Chiumento et al., 2011; O'Shaughnessy et al., 2011) and open-ended written questions (Fazel et al., 2009; King & Said, 2019; Hughes, 2014). For interviews and focus groups, reported methods of data collection included audio-recordings (Fazel et al., 2016) or note taking (Chiumento et al., 2011). Findings were presented in various formats, both descriptively (Chiumento et al., 2011) and after formal analysis (Fazel et al., 2016; O'Shaughnessy et al., 2012). Duplicate analysis by an independent researcher was reported in Fazel et al. (2016) and Said & King (2019). No studies commented upon completion of data saturation for themes or any processes of member checking to reduce bias. There appeared to be no

effect of data collection type (interview, focus group, written) or publication year on emerging themes.

Consensus occurred regarding the emerging themes of peer support (Fazel et al., 2016; Fazel et al., 2009; Chiumento et al., 2011; King & Said, 2019), alternative approaches to mental health difficulties (King & Said, 2019; Chiumento et al., 2011) and intervention setting (Fazel et al., 2016; Fazel et al., 2009; Chiumento et al., 2011). Most commonly, young people commented on the benefits of the intervention, emphasising reduction in mental health symptoms (Said & King, 2019; King & Said, 2019; Fazel et al., 2009; Fazel et al., 2016), but also feeling safe and listened to (King & Said, 2019; Fazel et al., 2016; Fazel et al., 2009). One quote extracted from Said & King (2019), is representative of the perceived improvement in mental health, *“It is extremely helpful. It benefits you on so many levels. It stores the problems you have through your life so it does not come to you unexpectedly any moment, you do not suffer from them as before”*. Other emerging themes included the impact of asylum process (Fazel et al., 2016), the supportive role of professionals including therapists and school teachers (Fazel et al., 2016) challenging aspects of interventions; *“after some of them [sessions], I would feel very difficult heavy feelings. I just find it so hard, I find it very emotional. I sometimes experience flashbacks”* (Said & King, 2019; Fazel et al., 2009).

Qualitative information was gathered from families in two studies (O’Shaughnessy et al., 2012; Hughes, 2014). Mothers in both studies identified similar themes of peer support and feeling safe, *“I know I’m not alone. The other women have given me so much”*. Additionally, they described themes of improved mother-child relationships and enjoyed psychoeducation including infant and child development and communication, *“it makes so much difference. It makes me to know my daughter much better, what she wants, what she doesn’t want”*. No information was collected from fathers, siblings or other family members in any of the included studies.

For those school-based studies, teachers discussed themes such as the helpfulness of location (Fazel et al., 2016; Fazel et al., 2009; Chiumento et al., 2011), the feelings of containment and relief, *“it takes the weight and responsibility of counselling off staff”* (Chiumento et al., 2011; Fazel et al., 2016; Fazel et al., 2009) and improvements to increase accessibility (Fazel et al., 2009).

Table 6: Summary of Qualitative Themes

<u>Themes</u>	<u>Said & King (2019)</u>	<u>Fazel et al (2016)</u>	<u>Chiumento et al (2011)</u>	<u>Fazel et al (2009)</u>	<u>King & Said (2019)</u>	<u>O'Shaughnessy et al (2012)</u>	<u>Hughes (2014)</u>
<u>Young People</u>							
Benefits of alternative therapies such as art, music (I couldn't have just talked about it, helps to make things)			X				X
Benefits of Group Work (peer support, share strategies)			X		X		X
Perceived Benefits of Intervention (effectiveness, self-confidence)	X	X	X	X	X		X
Challenging Aspects of Intervention (including hard to talk about experiences, increased symptoms, can be stressful)	X	X		X			
Benefits of community based location (ease, non-threatening, hospitals are scary)		X	X	X			X
Disadvantages of community based location (issues of privacy, peers mocking them, missed lessons)		X		X			
Positive relationship with clinician (trusted, caring)		X	X	X	X		X
Difficult and traumatic experiences	X	X	X	X	X		X
Difficulties in adjusting to Life in UK		X	X	X	X		X
Uncertainty about the future		X			X		X
Impact of asylum process		X					
Feeling safe		X		X	X	X	X
<u>Mothers</u>							
Benefits of Interventions for mothers (I know I'm not alone, pride in my culture, parenting strategies)					X	X	X
<u>Teachers</u>							
Benefits of Intervention for Teachers (Containment, improved outcomes for young people)			X	X			X
Disadvantages of Intervention for Teachers (So few children are seen)			X	X			
Role of Teachers (Understanding and helped me)		X	X	X			X

Discussion

This review provides support for the use of CAIs when working with young people with R/AS in the United Kingdom. Across the eleven different studies, each found clinical improvement for participants using a variety of methods. Several reviewed studies have shown support for cultural adaptations to evidence-based interventions such as narrative therapy (Said & King, 2019) or CBT (Ehnholt et al., 2005). Alternative treatments and supportive activities such as art, horticulture, culturally familiar food and activities also provided opportunities for young people and their families with R/AS to feel heard and supported (King & Said 2019, Chiumento et al., 2011). Some cultural adaptations were similar across many of the studies such as translated resources or inclusion of cultural values, whilst other adaptations were rarer; use of staff from native community (O'Shaughnessy et al., 2012; Hughes, 2014). Some qualitative data supported the involvement of families, schools and other support systems, by both validating and containing family and teachers but also improving outcomes for young people who may need more systemic support (Hughes, 2014; Vickers, 2005; Fazel et al., 2009). Research on attachment relationships emphasises the importance of a secure relationship for a young person's future progress and mental health (Heard, 2018).

These conclusions are in line with similar systematic reviews using international data (Fazel & Betancourt, 2018; Sullivan & Simonson, 2016; Slobodin & de Jong, 2015) suggesting that CAIs may be effective within outpatient and community settings. Turrini et al. (2019) found significant improvements to anxiety, depression and PTSD symptoms in adult refugees. Singular studies on child interventions also supported the use of culturally sensitive supplements to mental health interventions (Metzner, Reher, Kindler & Pawils, 2016; Hinton et al., 2012). To the researcher's knowledge, this is the first study to systematically examine CAI's for young people with R/AS, within the UK. This review was able to further add to the evidence-base for CAIs however it is important to acknowledge the limited statistical analysis of findings, due to issues with sample size and study heterogeneity.

Included Study Limitations

As with much of the research surrounding young people with R/AS, there are several limitations to be considered. The nature of working with young people with R/AS is a smaller pool of participants from which to recruit from and higher attrition rates due to unfamiliarity with social norms, stigma of mental health, practical barriers to accessing service such as relocation, asylum legal applications, (Ali et al., 2017; Dura-Vila et al., 2012). Two studies (O'Shea et al., 2000; Dura-Vila et al., 2012) used the same vignettes (names altered), perhaps highlighting the small population for recruitment. Of particular note, Ehnholt et al. (2005) added strict requirements of conversational English from

young people with R/AS, further reducing their sample size. This may also limit the generalisability of their results as young people would have to learn English before arriving in the UK, or have settled long enough in the UK to have learnt enough English. There is evidence that migrants may go through a 'cultural transition' regarding their beliefs about illness and intervention, as they continue to integrate into their host societies (Pumariiega, Rogers & Rothe, 2005). Evidence suggests that the duration of time in the UK before seeking mental health support influences both the types of difficulties and, therefore, intervention that young people would like to engage with (Dura-Vila et al., 2012) and is important for services to keep in mind while offering support.

Within the studies themselves, many used outcome measures available only in English and validated only within a Western population during peacetime (CRIES-8 & CPSS-5; Said & King, 2019; Ehntholt et al., 2005). Young people with R/AS often present with more complex trauma reactions, which may not fit within the PTSD criteria specified within the Western guidelines (NICE, 2018). As suggested by other researchers, unvalidated questionnaires may not capture the gravity of mental health difficulties if they only measure the Western symptoms (Gadeberg & Norredam, 2016; Stolk, Kaplan & Szwarc, 2017). More recently, there are mixed findings regarding the use of the SDQ in R/AS populations (Goodman, 1997), with adaptations such as translations or an additional trauma supplement (Stolk et al., 2017; Fängström et al., 2019). As this questionnaire was used by many of the included studies, findings should be viewed with caution. The addition of qualitative studies provided additional rich information about helpful and unhelpful aspects of the interventions (Said & King, 2019; Vickers, 2005).

Many of the reviewed studies also argue that a generalised universal, top-down approach may not be the most effective way of supporting young people from different ethnic backgrounds. Despite this, these studies recruited participants from 13 different countries, with many studies generalising cultures to similar geographical locations areas (Fazel et al., 2016). It is argued that young people from similar geographical locations will have vastly different cultural beliefs e.g. Israel and Palestine, and therefore even these CAI studies could be falling into the same trap of overgeneralising all young people with R/AS. On the other hand, for practical resources (resources and training), it may be necessary to have more generalised transferable skills with a more person-centred approach at an individual level rather than too culturally specific to one ethnicity.

Systematic Review Limitations

Despite the precautions taken to search grey literature, this review may be subject to publication bias. Enticott, Buck and Shawyer (2018) suggested governmental departments may be an additional source of literature, which is not often published on academic forums. Additionally, studies varied

significantly in methodology, model of therapeutic intervention and population. This is understandable, given the necessary creativity needed to engage the R/AS population, however the heterogeneity of studies limits the strength of findings. It was not possible to conduct a meta-analysis to support the statistical findings in included studies. Quality assessment and missing information highlighted weaknesses in addressing potential biases and limited the amount of information regarding implementation of interventions, respectively. Additionally, some of the cultural adaptations were poorly specified, and therefore, it is difficult to draw information about which components of CAI may be most helpful or unhelpful. Cardemil (2010) suggested that studies should, at a minimum, attempt to compare CAIs to standard treatment to directly assess the efficacy of additional cultural adaptations. It would, however, be costly and time consuming to reach sufficient sample sizes for a matched control sample. It may be possible to evaluate interventions based on engagement rates and qualitative feedback as a starting point (Weersing & Weisz, 2002).

There were particular issues with construct validity regarding the targeted area of mental health. It was difficult to determine the target difficulties for the majority of included studies, as they did not focus on presenting symptoms, instead appearing to be preventative interventions for everyday resettlement stressors. There are concerns about whether these studies are measuring the effectiveness of specific mental health interventions or general support programmes for young people with R/AS. The definition of what constitutes a mental health difficulty and therefore, intervention can be unclear in the R/AS population. Western frameworks around treatment may not fit with the presenting symptoms or with the specific strengths and coping strategies that are unique to young people with R/AS (Byrow, Pajak, Specker & Nickerson, 2020; Hughes, 2014). It may be argued that these studies were focusing on the first stage of trauma intervention; safety and stabilisation (Robertson et al., 2013; Laban, Hurulean & Attia, 2009), by providing psychoeducation and emotional support. Other studies focused on particular presentations of PTSD, anxiety, depression and poor educational attainment, and the effectiveness of evidence-based interventions, making it difficult to compare the two types of intervention.

Research Implications

Within research, the use of labels can narrow the focus of studies to Western ideas and approaches, and limit the extent to which researchers can learn from participants and therefore develop effective treatments (Beneduce, 2019). Clinically, professionals are then forced to choose between 1) acknowledging the broader social, economic and political contexts of R/AS mental health, possibly reducing the chances of accessing financial, health and legal resources or 2) labelling an R/AS child with an ill-fitting Western diagnosis, enabling access to increased, but potentially ineffective support (Watters, 2001; Beneduce, 2019). Attempts at 'culturally-sensitive' services, whilst honourable, can

also lead to poorly designed and tokenistic measures (Watters, 2001; Mansfield, Patalay & Humphrey, 2020). Ong (1995) found that bilingual therapists were listening to R/AS narratives, however translating these into defined constructs of Western mental health, rather than terms representative of the R/AS experiences. As outlined by Bracken, Giller and Summerfield (1997, p. 435), the aim of researchers is “not to impose order on the world but instead to allow the emergence of other voices and visions, even if this involves increasing complexity and ambivalence”. Rather than forcing limiting and dismissive categories on individuals who have experiences outwith the Western constructs of trauma, mental health and resilience, it may be most helpful to allow R/AS participants to first identify their own aetiology of difficulties (Hughes, 2014; O’Shaughnessy et al., 2012). Development of this approach as a research paradigm may help to better inform policy-makers and clinicians on how they can work collaboratively with a R/AS young person or family to identify true needs and an effective care-plan moving forward (Watters, 2001).

The complexity of conducting research with R/AS populations is widely documented (Ellis et al., 2007; Gaywood, Bertram & Pascal, 2020). As highlighted, the tailoring of interventions and the diversity of participants can prove difficult to quantify. Traditional methodologies, such as randomised control trials, could be criticised for their narrow inclusion criteria and implementation of treatment under artificial conditions (Butler, Fennell & Hackman, 2008; Westbrook & Kirk, 2005). It may be that practice-based evidence designs, including some approaches within the included studies, would address such limitations and provide meaningful, clinical implications for vulnerable young people who are often excluded due to language or complexity (van Wyk & Schweitzer, 2014).

It can, however, be difficult to step away from the traditional methods of mental health categorisation and study design. Based on the findings of this review, the following recommendations may be helpful when conducting research within R/AS populations, from a methodological perspective.

- An emphasis on qualitative research to define difficulties within R/AS context before attempting to quantify experiences across entire populations, e.g. with questionnaires or symptom checklists
- Inclusion of more young people with R/AS in clinical trials
- Explore the effects of ethnicity on treatment outcome
- Increase sample size of CAI studies
- Evaluate the efficacy of different components of CAIs
- Compare CAIs to treatment-as-normal
- Use culturally-validated outcome measures

- Long-term follow up of intervention outcomes

Clinical Implications

The majority of studies were non-randomised, community-based and reported sufficient levels of engagement with R/AS communities, despite the recognised barriers (Anderson et al., 2017; van der Boor & White, 2019). Mothers felt less alone with their difficulties (Hughes, 2014; O'Shaughnessy et al., 2012) whilst children felt listened to and able to confide (Fazel et al., 2016; Chiumento et al., 2011). It appears that these studies were able to address the stigma and barriers for R/AS populations and therefore may provide insight into how CAMHS and other health services could improve underutilisation of services, e.g. use of cultural brokers, practical supports etc.

One key element of seven of the included studies was the implementation of treatment within a school location. Schools may provide an ideal setting to access young people, as they are often of key importance for integration and opportunities for the future (Tay & Silove, 2017). As suggested in Entholt et al. (2005) meaningful interventions for young people and their families could be completed by many professional disciplines including teachers, mental health nurses or art therapist, if training is provided (Fazel et al., 2009). This could preserve CAMHS and other specialist services for young people who are experiencing the most severe mental health difficulties.

Within the reviewed studies, there has been a highlighted difference with regards to evaluations of novel services compared with adaptations to pre-existing evidence-based interventions. Although both have suggested their efficacy within the UK, it must be noted that all interventions, excepting one study (Vickers, 2005) were completed within specialist services for young people with R/AS. Although it is promising to see specific provisions set up for this population, it is particularly important to highlight in the context of increasingly limited resources and understaffed services, that this may not be possible across all NHS boards.

Medical models of mental health are not merely scientific labels, but also a means for financial support, resource allocation and treatment availability. Although the traditional model of diagnosis-led treatment has some benefit, it dismisses many of the socio-economic factors which contribute to both the development and presentation of R/AS mental health difficulties, e.g. status uncertainty, loss, acculturation and discrimination, (Summerfield, 2001; Kirmayer et al., 2011). Additionally, whilst considered a symptom of 'repressed' emotion in Western cultures, many cultures recognise an explicit relationship between emotional difficulties and physiological symptoms (Scheper-Hughes, 1992; Watters, 2001). The Western categorisations of mental health can also fail to account for the unique strengths and resilience needed to manage difficulties generally not experienced by peace-time populations, including torture, military conflict, severe poverty, and extreme and continuous

danger (El-Khodary & Samara, 2020; Fino, Mema & Russo, 2020). Finally, there are dangers to ‘lumping’ all R/AS experiences together, without regard for country of origin or ethnicity. Although some social norms may be similar regarding hospitality or family dynamics, there are significant differences in cultural values and belief systems. Even with a formulation-led approach, it can be difficult to encompass the various cultural norms and thinking styles from different countries and ethnic origins (Tay & Silove, 2017).

This review may highlight methods to providing high-quality care to young people with R/AS, a key aim of the New Scots Strategy (2018-2022). The models used in the included studies may be novel and not considered well enough established to currently inform policies and practice. However it is hoped that continuing to increase the evidence base for alternative and existing interventions may encourage researching and using more creative ways of working with young people who do not fit into the traditional CAMHS service model.

Conclusions

Although empirically-supported treatments for young people with R/AS are not well established, there is a growing evidence base to support the use of cultural adaptations to mental health interventions, with the aim to meet unique needs. This systematic review provides information for clinicians, services and policy makers about the efficacy of CAI within a UK public health settings. Most would agree that differences in ethnicity, religion, gender or nationality should not be barriers to high-quality professional care. Services must adapt to the increasingly multi-cultural population that require support within the population, without assuming homogeneity of all ethnic minorities. Although not yet defined, there is promise for developing psychological frameworks and political policies on how UK services can best support families with R/AS.

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Abstract

Objective: The effective integration for refugee and asylum-seekers across multiple areas of daily living has been underpinned by The New Scot's Strategy (2018-2022). Unfortunately, the voices of those directly involved in refugee resettlement are often not captured, and therefore not taken into account. This study aims to explore and triangulate the lived experiences of key stakeholders in the process of social integration.

Methods: Interviews and focus groups were conducted across three participant groups; refugee young people, refugee families and staff from various organisations involved in refugee care. Recruitment difficulties were addressed using non-traditional approaches and ethical considerations were noted. Interpretative Phenomenological Analysis (IPA) was used to identify and explore themes from the data.

Results: Common themes emerged across all three participant groups; *Trust & Safety, Connection & Disconnect, Meeting Needs* and *Identity*. Other themes were particular to either refugee participant groups or the services group. All groups expressed feelings of uncertainty and unease at the difficulties of communication and trust across such different cultures and social norms.

Conclusions: This study used a polyvocal IPA approach to explore the complexities of refugee resettlement in Edinburgh, Scotland. Limitations of the research are discussed. It is hoped that the insights from refugee families and staff working with these families provide areas for meaningful change. Implications for clinical improvements and future research are highlighted.

Introduction

Refugees in Scotland

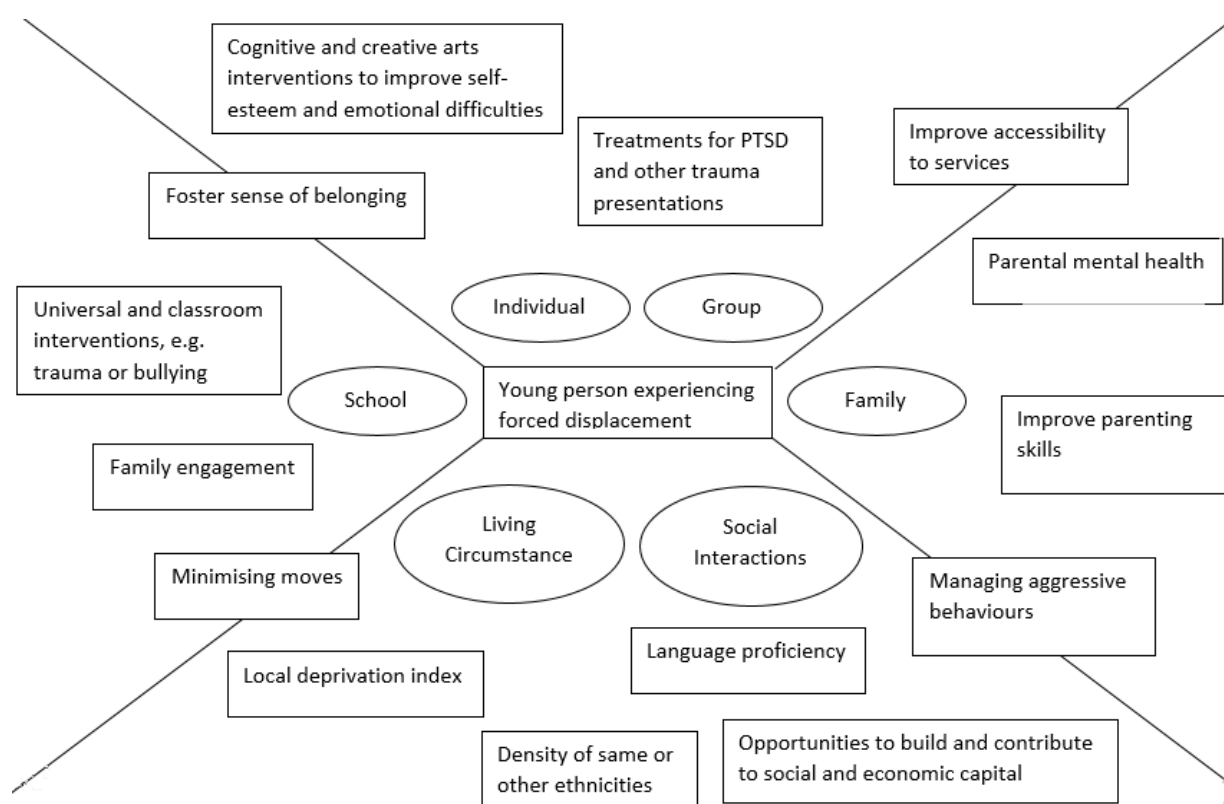
A refugee or asylum-seeker (as defined by the UN Convention 1951), is an individual who has been forced to leave their country for fear of persecution due to race, ethnicity, religion, social group or political belief. It is estimated that half of all refugees and asylum-seekers arriving to the United Kingdom are children and adolescents, entering either as a dependant (part of a family group), or as an unaccompanied minor, approximately 1825 young people (UNHCR, 2004). It is well documented that early experiences can lay the foundation for the long-term wellbeing and future outcomes for children (Heumer et al., 2009; Bowlby, 1982). Often individuals with refugee or asylum seeker status (R/AS) have experienced uncertainty, trauma and loss before leaving their home country (El-Khani & Calam, 2019). They may continue to experience challenging circumstances such as poverty, refugee camps and family separation in other countries along their journey (Crawley, 2010). Upon arrival to a host country, difficult memories may also be exacerbated by the everyday stressors of attempting to resettle and integrate within an alien culture (Turrini et al., 2017; Leaning, 2001; Gorst-Unsworth & Goldenberg, 1998).

Models for Resettlement

The Adaptation and Development After Persecution and Trauma model (ADAPT; Silove, 2000) posits there are five pillars to psychosocial adjustment for refugee resettlement; safety, attachment, justice, identity and meaning. Although these domains are distinct, there is a strong interaction between them; when one of these pillars is less stable, it can lead to challenges in other areas of the structure (Yohani, 2015). Additionally, Groark, Sclare and Raval (2011) considered the effect of time on the adjustment process. Initially young people required safety and stability, with the development of trusting relationships and access to healthcare and education in later months (Groark et al., 2011; Maslow, 1943). Furthermore, Ager and Strang (2004) interviewed R/AS individuals and developed a framework of distinct domains to facilitate integration, including social communication, housing, education and health, based on a foundation of awareness of individual rights. They stressed the interdependence of all domains and the importance of services facilitating links between each area of integration.

To promote resettlement for newly arrived young people, factors such as those outlined by Fazel & Betancourt, (2018; see Figure 1), a systemic approach is essential. Emphasis on building social connections in the Scottish community and encouraging positive contribution to their host country is paramount.

Figure 1: Preventative Model for Mental Health Difficulties, (adapted from Fazel et al., 2018)



The second New Scots Strategy (2018-2022) aims to be a holistic approach coordinating the efforts of private and public services, emphasising six key themes; needs of dispersed asylum seekers, employment & welfare, housing, education, health and community & social connections (Scottish Refugee Council, 2017). Furthermore it attempts to address some of the challenges outlined in the previous New Scots Strategy (2014); lack of meaningful involvement for refugee communities, over-reliance on the goodwill of others, limited access to education and language skills acquisition (Scottish Refugee Council, 2017). Where multiple issues can be addressed, it may be that the need for long term mental health care is reduced within R/AS populations (Beauchaine, 2017).

Experiences of Refugee Resettlement

Despite multiple models for refugee resettlement, there has been little evaluation of how R/AS young people and their families experience government policies. Generally, research into resettlement experiences of R/AS families has focused on pre-selected difficulties and pre-conceived symptoms (Thommessen, Corcoran & Todd, 2015; Fazel et al., 2012). In order to provide effective support for integration, it is essential to first listen to the wider experiences of young people and families with R/AS and the professionals supporting them, before making hasty, crisis-driven decisions.

By the very nature of resettlement, refugees find themselves living between two worlds; their previous lives and the ones they have in their host country. Thommessen et al. (2015) used a qualitative approach to explore the resettlement experiences of unaccompanied minors resettling in Europe. They found several themes; *From Danger to Safety*, *Living in Limbo*, *Guidance and Social Support*, and *Striving to Fit in and Move Forward*. Other studies have identified that social connection, finding meaning in previous experiences and the development of future goals are of particular importance for R/AS families (Goodman, 2004; Miller et al., 2002).

When young people and families with R/AS require mental health support, it can be difficult for services to determine the most appropriate approach. Staff may advocate the use of evidence-based treatments which they feel more confident implementing, however this may dismiss cultural sensitivities, collectivism and lesser-known coping strategies (Summerfield, 1999; Silove, Ventevogel & Rees, 2017). There have been a number of service evaluations providing clinical care for R/AS young people (Pfefferbaum, Nitiéma & Newman, 2019; Fennig, 2020; Fazel et al., 2012), reporting difficulties such limited resources, lack of cultural knowledge and practical barriers to engagement (van der Boor & White, 2020; New Scots Strategy 2018-2022). Murray, Davidson and Schweitzer (2010) completed a systematic review of 22 studies exploring mental health interventions and found that there was a need for services to move away from a medicalised model as this could cause engagement difficulties. Additionally, mental health provision in schools described attempts to facilitate a sense of belonging for R/AS children, with the use of buddy systems and group work, rather than traditional individual therapy approaches (Kia-Keating & Ellis, 2007; Fazel et al., 2016). Guhan and Liebling-Kalifani (2011) used a grounded theory approach to explore the experiences of UK staff working with the R/AS population. They found several themes including reaping rewards, personal impact and the importance of training and supervision. Staff felt that the system in which they worked limited their ability to provide best-quality care for individuals with R/AS (Guhan et al., 2011; Century, Leavey & Payne, 2007).

Rationale

A principal role for researchers is to bridge the gap between policy-makers, community services and service-users (Titterton & Smart, 2008). Exploring the impact of resettlement on each stakeholder is essential for producing guidance, and supporting young people and their families with R/AS. Unless members of cultural groups are consulted and allowed to voice their perspectives, the opportunity for meaningful change may be lost (Falcón, Todorova & Tucker, 2009).

Due to the increasing number of people seeking asylum in the UK, it is vital that host community services are equipped to deal with the unique challenges that R/AS may face. While there is some research into the difficulties of resettlement, there are limited studies focusing on the perspectives of children and young people, and the effect of their experiences on mental health. Additionally, there is a dearth of literature on (i) how young people with R/AS status perceive and/or experience Health and Social Care services in the UK, and (ii) whether they have unmet needs regarding mental health (Nadeau et al., 2017; McGuirk & Button, 2013).

It is anticipated that meaningful feedback from young people and the wider refugee community will allow individuals in Scotland to understand some of their resettlement experiences, the effects these experiences may have on emotional wellbeing and provide implications for the development of services (Dyregrov, Dyregrov & Raundalen, 2000). Additionally, allowing professionals to voice their concerns about working with young R/AS may provide opportunities for development of services to manage unique challenges, both at a front-line and management level. Only then can Scotland begin to develop mental health services appropriate to R/AS unique needs, within the wider context of integration.

Aims

The current study aims to explore

1. The experiences of young people with R/AS resettling in Edinburgh, with particular focus on mental health and access to appropriate services
2. The experiences of R/AS family members and gain their perspective on resettlement for both themselves and their children
3. The experiences of staff and volunteers involved in the psychosocial care of young people with R/AS, i.e. Health & Social Care and various charities.

Ethics

Ethical approval was gained from both NHS Lothian and University of Edinburgh ethical committees, see Appendix E.

Emmanuel, Wendler, and Grady (2000) propose seven ethical considerations when conducting research with the R/AS community. Due to the potential vulnerability of the population, every effort was made to reflect upon these issues (Ellis et al., 2007).

(1) **Social or Scientific Value:** The value of research can be measured by its contribution to enhancing care for the participant group. There is great potential for this study to provide knowledge for improving support for young people and their families with R/AS, with meaningful input from service-users. It is typical for research to be circulated within academic groups, however distribution of findings for the R/AS community and community workers requires additional consideration. The study findings will be presented on a summary sheet, available in both Arabic and English, for dissemination amongst the participant groups and wider community.

(2) **Scientific Validity:** Poor quality studies can lead to false conclusions, wasted resources, and at worst, may cause harm (Hugman, Pittaway & Bartolomei, 2011). Within refugee populations, it may be more complex to ensure quality control, due to unvalidated measures and a lack of participation in mainstream research (Ellis et al., 2007). The researcher aimed to increase validity of findings by triangulating multiple sources of information, being transparent with the analysis of data, and using participant validation (Elliott, Fischer & Rennie, 1999).

(3) **Fair Subject Selection:** Many studies exclude participants for convenience reasons such as language and complexity, resulting in research that is not generalizable to community settings due to the narrow and superficial sample size (Westbrook & Kirk, 2005). This study endeavoured to encourage participants from all R/AS communities and was open to staff from both public and private services. Non-English speakers were not excluded. Study materials were initially translated into English and Arabic, and other translations were available upon request. The researcher approached a wide variety of services to ensure fair subject selection.

(4) **Favourable Risk to Benefit Ratio:** Whilst the R/AS population is often perceived as vulnerable, there is a risk of protecting participants to the point of excluding them from research altogether (Kilpatrick et al., 2004). This itself can become unethical as organisations are then unprepared for managing the unique needs of the R/AS population. Every effort was taken to reduce the risk of psychological distress to participants, including ensuring that participants would not be asked about their previous and often traumatic experiences of war. Participants were also asked for consent to

contact a family member, support worker or GP if the researcher felt this was appropriate, with regards to risk. Phone numbers such as NHS-24 or Samaritan's Helpline, were also provided in case of any participant experiencing psychological distress.

(5) **Independent Review:** The input of experts by experience within the Delphi design approach allowed for independent review of study materials and protocol, see Study Design for more details.

(6) **Informed Consent:** The use of translated study materials and opportunities for participants to use interpreters ensured that language was not a barrier to informed consent for R/AS participants. All potential participants were also given the opportunity to review study materials for at least 24 hours and ask any questions, as described in Study Procedure.

(7) **Respect for Potential and Enrolled Subjects:** The researcher attended a workshop on Ethics in Global Mental Health to identify difficulties which may arise during the study (Calia, Grant, Reid & Guerra, 2020). Numerous issues were considered including an outsider-insider approach (Dwyer & Buckle, 2009), the importance of cultural sensitivities (Schweitzer et al., 2008) and the position of power afforded to the researcher by her job role and ethnicity (Gaywood, Bertram & Pascal, 2020). These considerations are discussed in detail within the Reflections section.

Finally, all collected data was anonymised and stored in locked NHS cabinets in secure NHS sites in accordance with NHS and University of Edinburgh GDPR guidelines.

Methods

Study Context

Sigona (2014) emphasised the importance of providing a social and political context of the study in order to effectively represent the lived experiences of refugees. This research study was conducted in 2019-2020 in Edinburgh, Scotland within the context of an increasing population of refugees and asylum-seekers arriving into the country. It is estimated that 40% of the UK's recent R/AS community are currently residing in Scotland, approximately 1,825 young refugees (Home Office 2019; Scottish Refugee Council, 2017).

Despite Edinburgh being the capital city, the majority of refugees have been settled in Glasgow. As a consequence, the resources and organisations supporting R/AS resettlement are primarily based in Glasgow. This requires those settled in other locations around Scotland to travel to Glasgow for Home Office interviews, engagement with charities and, even access to familiar foods. Additionally, there are vast differences in culture between areas of Scotland, perhaps influencing the effectiveness of strategies used in different areas e.g. community mentoring programme (Scottish Refugee Council, 2017).

The New Scots Integration Strategy (2018-2022) reports that only 9% of the literature guiding refugee policy is focused solely on health and wellbeing. A systematic review of R/AS response rates within mental health research indicated wide variation, 41-97.1% response rate (Enticott et al., 2017). Research exploring mental health in refugee populations indicates that recruitment difficulties may arise from stigma, distrust of authorities, cultural sensitivities (Schweitzer et al., 2008; Ali et al., 2017).

Study Design

This study used a qualitative design to highlight the experiences of key stakeholders involved in the resettlement of young refugees and their families in Edinburgh. Quantitative designs were ruled out due to the paucity of child and adolescent outcome measures validated within an R/AS population (Stolk et al., 2017). Additionally, the process of resettlement is not a static construct and may change over time, and therefore it was felt that a quantitative design would not fully capture the complexities of refugee resettlement and the rich narratives of those involved.

Although other qualitative methodologies were considered, such as grounded theory or thematic analysis, Interpretative Phenomenological Analysis (IPA; Smith et al., 1999) with an element of ethnography (Reeves, Kuper & Hodges, 2008) was chosen to be the most appropriate methodology for this study. IPA is underpinned by three main theoretical frames; phenomenology, hermeneutics

and idiography (Smith & Osborn, 2008). Phenomenology asserts that individuals construct their realities according to their own experiences (Willig, 2001). It acknowledges that the accounts shared with the researcher are not objective, nor can the researchers claim objectivity when exploring the participants' experiences. Influenced by the work of Husserl (1927) and Heidegger (1962), the 'double hermeneutic' approach proposes that 'the researcher is trying to make sense of the participants trying to make sense of their world' (Smith & Osborn, 2015, p. 26). The idiographic approach of IPA allows the researcher to recognise similarities and differences between the participants' experiences, whilst still staying true to each narrative, i.e. how does *this* person experience something and how does *this* person make sense of it? (Willig, 2001; Smith et al., 2008). In this way, the individual voices are heard throughout the analysis. As this study is concerned with discovering the unique perspectives of three participant groups, it was felt that a phenomenological approach would be best suited to capture the emotional complexities and ambiguity of this topic. Additionally, the idiographic approach to IPA allows some recognition of the heterogeneity of individual experiences, something often lost in refugee research (Hek, 2005; Larruina & Ghorashi, 2020).

IPA methodology proposes the use of semi-structured interview schedules, with the potential for flexible divergence from the script, when exploring topics that may arise during the interview (Smith et al., 2008; Smith & Eatough, 2007). Interview questions were designed to explore three specific areas of interest (i) resettlement experiences, (ii) mental health and (iii) access to services. Within refugee research, there is a tendency for researchers to focus on trauma as a main narrative, dismissing the more everyday stressors and coping strategies of R/AS human experiences (Schweitzer et al, 2008). In line with Schweitzer et al, (2008) and examination of similar previous studies (Nadeau et al., 2017; Mirdal, Ryding & Essendrop, 2012; Frounfelker et al., 2017), initial questions aimed to gather demographic information and create therapeutic alliance. Later questions aimed to be neutral and open-ended to allow participants to express their own accounts of resettlement, without bias.

This study also used a Delphi design approach (Kezar & Maxey, 2016) in two aspects of the research; developing an interview schedule and during transcript analysis. This approach is particularly useful in areas with limited research (Iqbal & Pison-Young, 2009)

- Identified experts are asked for specific feedback on each question, and general feedback on the language used, within the context of cultural sensitivity
- Alterations made as a result of the experts' feedback
- A draft schedule is then re-presented to the experts for further feedback

Initial interview questions were first piloted with one charity (one staff member and one young person) and then a second charity (one staff member and one young person). As a result, language such as 'mental health' that was considered stigmatising for the targeted population was consequently revised, e.g. well-being. Feedback indicated that questions may be too open to accommodate language barriers. It was therefore decided to split questions into smaller topics, e.g. *'Can you tell me about your experiences of moving to Scotland?'* changed to *'Can you tell me the positive things about moving to Scotland?'* and *'Can you tell me about what has been difficult about moving to Scotland?'* The semi-structured interview schedule for is included in Appendix F.

During data analysis, the researcher employed the Delphi design by first identifying themes from the interview information gathered from young people, families and staff. These conclusions were then sent to participants, for comments upon the accuracy of initial data analysis and their perspectives on the results. This additional information was collected via email due to COVID-19 restrictions.

Participants

Research into Interpretative Phenomenological Analysis (IPA) proposes a sample size of 6-8 participants is sufficient to glean detailed data (Pietkiewicz & Smith, 2014), with a maximum number of 15 cases (Smith et al., 2008). This allows the researcher to complete detailed individual case studies, ensuring the quality of information gathered, accounting for limited time and population resources. Participants were recruited using the following inclusion criteria,

- Young People:
 - Children and adolescents aged 10-18 years old
 - Refugee or asylum- seeker status (as specified by UN Convention 1951)
 - Dependants (with their families) or unaccompanied minors
 - Currently living in Edinburgh (no restrictions on country of origin)
- Family:
 - Any family member/legal carer of young refugees living within Edinburgh, e.g. parents, grandparents, siblings (>10years old) etc.
- Professionals:
 - Staff and volunteers from public and private organisations, who provide psychosocial support to child and adolescent refugees currently, or within the past 6 months

Exclusion Criteria: Any participant (young people, family member or professional) with particularly acute mental health needs at the time of the study.

Procedure

Figure 2 outlines the procedure for recruitment and data collection between September 2019 and March 2020. Participant information sheets and posters were provided to NHS locations across Edinburgh that supported young people, including those with R/AS, e.g. CAMHS, (see Appendix G for all recruitment materials available in English and participants' native language, generally Arabic). Multiple NGO's and charities supporting young people and families with R/AS were contacted via email and in person and provided with information sheets. Local colleges were also contacted in an effort to identify families or young people learning English as a second language.

Anecdotal advice from volunteers was that R/AS families are an over-researched group and that both staff and families would be more willing to participate in interviews if they had already build a relationship with the researcher, and viewed the researcher as able to provide meaningful change (Marlowe, 2010). Studies have suggested the researcher-participant relationship should be perceived as similar to a 'family friend' or 'accepted guest', with boundaries that may be flexible and very different to a traditional research project (Bang & Finlay, 1987; Gaywood et al., 2020). The researcher therefore used a semi-ethnographic approach, attending regular charity activities including weekly playgroups, a peer support group for R/AS men, English classes for women and various fundraising events, see Reflections. An extensive list of organisations contacted is available in Appendix H, and response rates are highlighted within Results. Additionally, a snowballing technique was used within the R/AS community, whereby participants were asked to identify friends and family who may be interested in participating. These individuals were then provided with information sheets about the study. This variety of techniques used were considered essential, due to the recruitment difficulties within the R/AS population.

Clinical staff were asked to complete a capacity assessment (to determine eligibility criteria) before providing leaflets to young people. Age appropriate participant information sheets were distributed to any young person interested in participating in the study. Participants were asked to view the material for a minimum of 24 hours before contacting the researcher. If the young person showed interest in participating, capacity was reassessed by the researcher and they were asked to complete a written consent form before completing the interview. An interpreter was provided to ensure young people were fully informed, in their native language, before consenting to the study. Young people were also given the option of using an interpreter throughout the interview. Participants were informed that they could refuse to answer particular questions and that the interview could be ended at any time, at the participants' request.

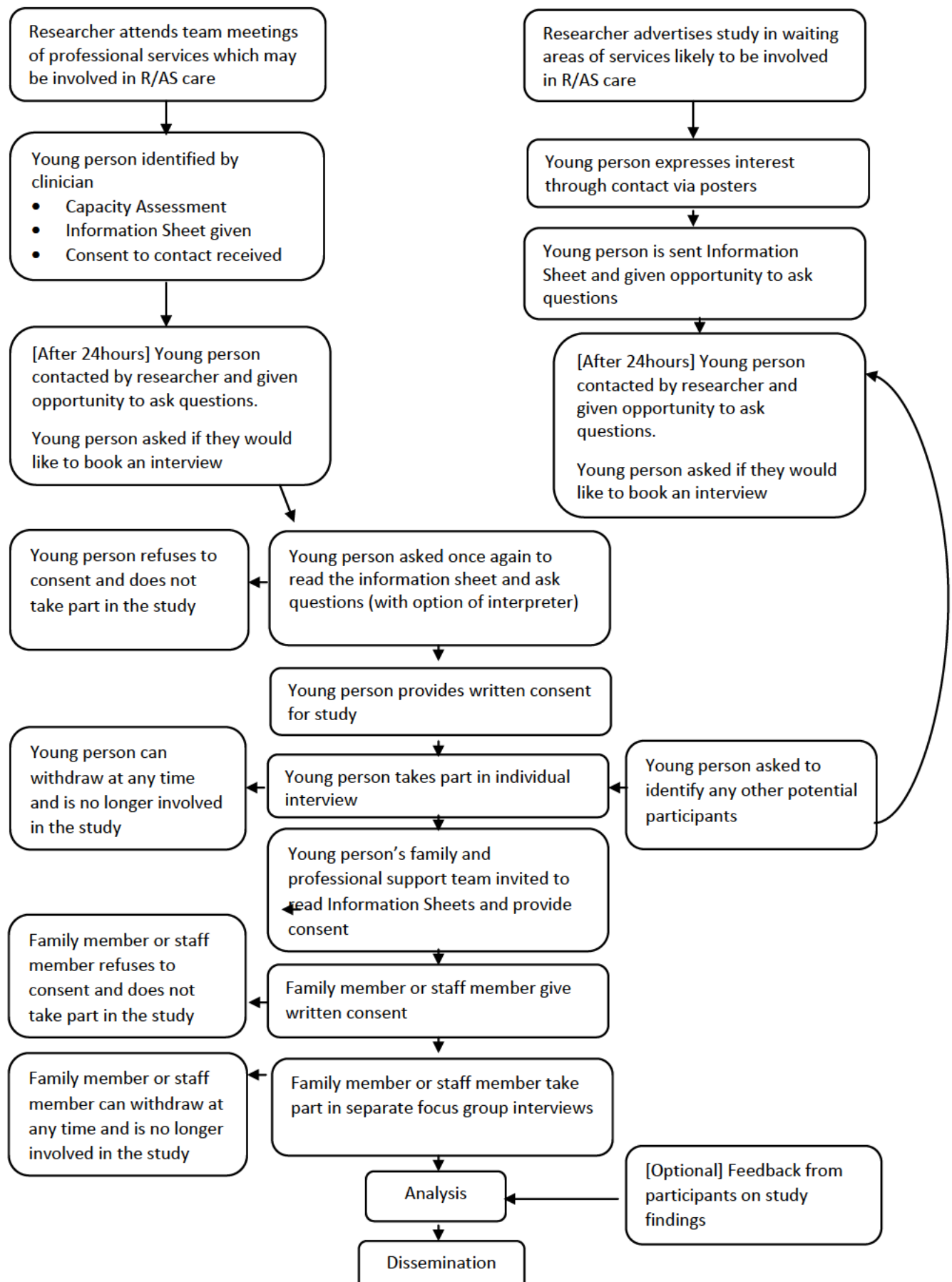
The interviews were conducted by the researcher, in an environment familiar to the participant, e.g. quiet room within the recruitment location. The interviews for young people lasted approximately 20-30 minutes and participants were given the opportunity to have a parent or supportive adult to join them in the interview. Individual interviews for young people were selected to allow appropriate space for participants to share their experiences without fear of expressing vulnerability in front of peers. This was considered especially important, given the developmental stage of participants and the perceived importance of their peers' opinions (McCoy, Dimler, Samuels & Natsuaki, 2019). Demographic information such as age, gender and ethnicity was collected separately. Participants were also asked to provide optional contact information if they wished to be provided with a summary of the study findings.

The parents/carers of young people were invited to participate in hour long focus groups to explore the family perspective of resettlement in Scotland. A strength of focus groups is the ability for one participant to create momentum for other participants to share their own experiences (Guest et al., 2017). Within the R/AS community, social relationships are extremely important and it was felt that families may feel more comfortable opening up to a researcher if others were able to validate their experiences. Families were given the option of focus groups consisting of one whole family, or split into groups of mothers and fathers. An interpreter was available and each group member was also given the opportunity to speak with the researcher individually, if desired.

Staff members working within public services and charities working with young people with R/AS were invited to discuss their experiences and what may help to support both staff and young people with R/AS during their interactions. Aiming to be sensitive of professional time constraints, staff members were also given the option of completing written answers to questions if an appropriate group time could not be set up.

All interviews and focus groups were audio-recorded and notes were taken by the researcher to describe non-verbal cues. The interviews were manually transcribed and anonymised by the researcher and checked twice for accuracy. Transcriptions containing Arabic were checked with a second interpreter, independent from the interpreter taking part in the interview. Discrepancies regarding the translation were discussed between the researcher and two interpreters until consensus was reached. A transcription key (Appendix I) indicates the symbols used to identify nuances in speech and non-verbal occurrences.

Figure 2: Study Procedure



Data Analysis

Interpretative Phenomenological Analysis (IPA; Smith, Jarman & Osborn, 1999) was used to manually analyse data collected from each participant group. Steps taken were guided by Smith & Osborn (2004)

- Transcripts were read and re-read by researcher individually.
- Within group interviews, individual stories were also highlighted and read repeatedly
- The researcher noted personal observations and thoughts in left margin.
- Themes in each transcript were written, in the right margin, see Appendix J.
- Potential common themes were grouped together and examined for connections. These were traced to relevant quotes to ensure evidenced based themes.
- Themes not backed up by transcripts were omitted.
- Shared themes were identified from all transcripts, to ascertain common experiences from each participant group.
- This process was overseen by the academic and clinical supervisors in order to enhance validity of results.

Themes may be identified through descriptive comments (related to content), conceptual comments (related to more abstract and conceptual theories) and linguistic comments (related to specific use of language) (Smith et al., 2008). The type of language used, e.g. emotive words, can provide greater insight into lived experiences and is also associated with predicted outcomes regarding PTSD symptoms, however it was felt that language analysis would not be appropriate in this study (Wardecker et al., 2017; Bailey, McIntyre, Arreola & Venta, 2019). R/AS participants were often speaking in their second, third or fourth language and therefore may have been relying on particular words through necessity, rather than choice.

Complex processes such as refugee resettlement involve several distinct parties and therefore require the use of multiple perspectives to gain true insight into such experiences (Rostill-Brookes, Larkin, Toms & Churchman, 2011; Glasscoe & Smith, 2011). Interviews from young people were analysed together, followed by separate analysis of family groups and finally professional focus groups, before comparison between groups in the wider framework of the study, see Figure 3. The subsequent triangulation and comparison of different sources allows increased accuracy of data (Smith, 1999; Larkin, Shaw & Flowers, 2018). Similar themes from each participant group will be combined, whilst themes that are not present across groups will also be explored, in acknowledgement of the different perspectives within the phenomenon of refugee resettlement.

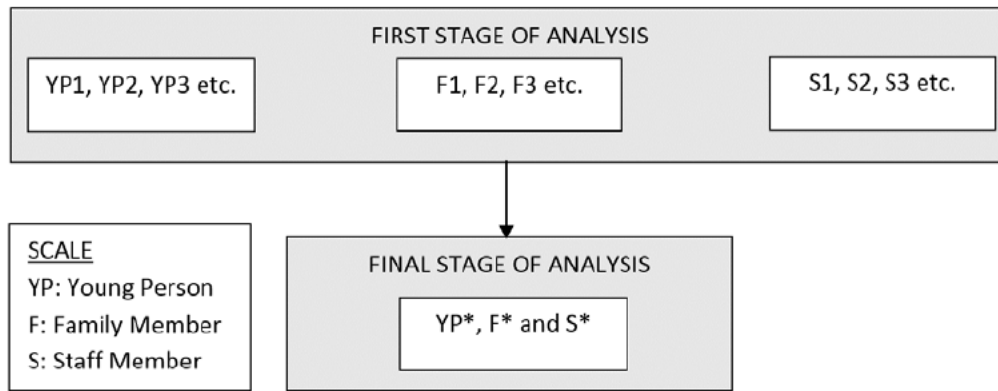


Figure 3: Process of IPA Analysis

Hoffman (1990) suggests that everyone views the world through particular ‘lenses’, shaped by previous experiences. These ‘lenses’ affect the way we perceive our lives and our social relationships with others (Yardley, 2000). I am a Caucasian female in my last year of clinical psychology training. I was brought up in Northern Ireland where I have some experiences of growing up in armed conflict. I do not have experience of extreme persecution or being forced to leave my country, such as the participants in this study have experienced. I have developed superficial awareness of the difficulties faced by R/AS families and staff whilst volunteering with several specialist charities. As per Larkin et al. (2018), a reflective diary was kept during recruitment, data collection and analysis to identify any potential biases and document their personal journey (see Reflective Account).

After initial analysis and emergence of themes, preliminary findings were emailed to participants who had given contact details. As described in Study Design, this feedback and additional perspectives on the initial data were added to the analysis.

After completion of analysis, results were reported in this dissertation and were also available in summary form, to all those involved in the study and the R/AS community as a whole, see Appendix K. Plans to present findings and implications of the study to parties involved, have been delayed by COVID-19, however it is anticipated that this will occur at a later date.

Results

Response Rates

The researcher contacted a large number of organisations who were likely to be involved in supporting young people and families with R/AS, see Appendix H. Response rates were considered extremely low and perceived barriers included protectiveness from services about recruiting R/AS families, disinterest at a service level and individual level and a distrust in the researcher's 'outsider' status.

Of the 57 Services contacted, young person participants were identified through two educational organisations. No young person participants were recruited through public services such as NHS Lothian or Social Services due to lack of appropriate participants and lack of ethical approval respectively.

Family members attended gender specific groups run by one R/AS charity. Mothers were recruited from a support class which provided English lessons whilst volunteers provided childcare. A Men's Group was also approached and several fathers showed interest in participating. Unfortunately due to COVID-19 restrictions, the fathers' focus group was not able to take place.

Staff from several public services and charities were approached and expressed an interest in sharing their experiences of working with R/AS families. Of the 52 services approached to recruit staff participants, focus groups were conducted across three organisations.

Participant Characteristics

Six young people aged between 15 and 18 years old, completed the initial interviews, see Table 1 for demographics. Interviews were conducted in private rooms in the recruitment location, with a mean duration of 23 minutes and 51 seconds (ranging from 20.52-28.20). One young person requested an Arabic interpreter, however preferred to complete the majority of the interview in English. All young people were born in Syria and had lived in at least one other country during their journey to Edinburgh; Jordan, Lebanon or Iraq. All participants had arrived in Scotland with family members, as part of the Vulnerable Person's Resettlement (VPR) Scheme. All participants had lost family members and friends due to the Syrian conflict; three young people had lost their fathers. Five young people were attending school whilst one young person attended English classes at college. Due to their recruitment pathway, young people were not asked about any physical or mental health diagnoses. No participants presented with risk behaviours or overwhelming distress, negating the need for contacting NHS-24, Samaritan's Helpline or a trusted adult.

A parent focus group was attended by five biological mothers and lasted approximately one hour. One mother left the interview early due to childcare difficulties, however she consented for the researcher to use her information. An Arabic interpreter was used during the focus group for biological mothers. This interpreter voiced a desire to share her own experiences within the interview, completed written consent, and subsequently became the fifth parent to participate. The foster carer of an unaccompanied minor from Ethiopia completed a separate individual interview to share her experiences (lasting approximately two hours).

Fourteen staff members and volunteers, across three services completed separate focus groups (duration ranged from 45-59 minutes). Two services were NHS teams; one had expertise in child and adolescent mental health whilst the second service supported looked-after and accommodated young people. The charity specialised in psychosocial support for ethnic minority young people and families, with a particular interest area with those with R/AS. Professional disciplines included mental health practitioners, social workers, occupational therapists, clinical psychologists, art therapists, project workers, charity CEO and volunteers.

Table 1: Participant Demographics

Young People (N=6)	Mean Age	17 (15-18 years old)
	Gender	5 male, 1 female
	Ethnicity	6 Syrian (2 Kurdish)
	Journey Countries	2 Jordan, 2 Lebanon, 2 Iraq
	Mean Time in Scotland	2.2 years (1-3.5 years)
Parent/Carer (N=6)	Gender	6 female
	Relationship with Child	5 biological parents, 1 carer
	Ethnicity	5 Syrian (2 Kurdish), 1 UK (carer)
	Mean Time in Scotland	2.9 years (4 months-5 years)
Staff (N=14)	Gender	12 female, 2 male
	Service	2 NHS services, 1 charity

Two young people with R/AS participated in the optional secondary data collection and reported agreement with the findings of the study. Comments via email allowed the researcher to explore how these young people perceived and understood the emergence of these particular themes.

Themes

A range of superordinate themes and corresponding subthemes were identified during the analysis, (Appendix L), and are explored in detail. Individual case analysis (Appendix M) identified sub-themes which were subsequently grouped into super-ordinate during cross-case analysis. Themes generally spanned across time, incorporating experiences previous to leaving their home country, during the migratory journey and after arrival to Edinburgh. The themes varied across participant group

- Young Person: *Trust & Safety, Connection & Disconnect, Loss & Longing, Meeting Needs and Identity*
- Mothers: *Trust & Safety, Connection & Disconnect, Loss & Longing, Meeting Needs and Identity*
- Services & Carer: *Trust & Safety, Connection & Disconnect, Meeting Needs, Identity, Unknown & Uncertainty and Vocational Discord*

Although the carer participant may be classified demographically within the family member group, the themes identified within this interview were influenced by the carer's cultural and professional experiences. The carer's information was therefore grouped with the staff participants.

As there were clear overlaps in themes between the participant groups, it was felt that combining the three narratives would highlight the similarities in participants' perspectives. Care was taken to ensure preservation of the unique lived experiences of each group were heard (Smith, 2017). Where themes were not similar throughout the groups, (e.g. *Unknown & Uncertainty*), these were also explored. The interaction between all themes is illustrated and described in Appendix N. Figure 4 displays the contact of themes between the three participant groups, whilst Figure 5 highlights the cross-group analysis, and combining of themes. Each super-ordinate theme and corresponding sub-theme is discussed in turn. The analysis will first provide a description and the researcher's interpretation of each identified theme, and secondly use the existing literature to consolidate the participants' account. Pseudonyms have been used to protect participant confidentiality.

Quotes will be presented using the following format:

Name (Page & Line Numbers) "Quote" (Participant Group; YP- Young Person, M- Mothers or S- Services)

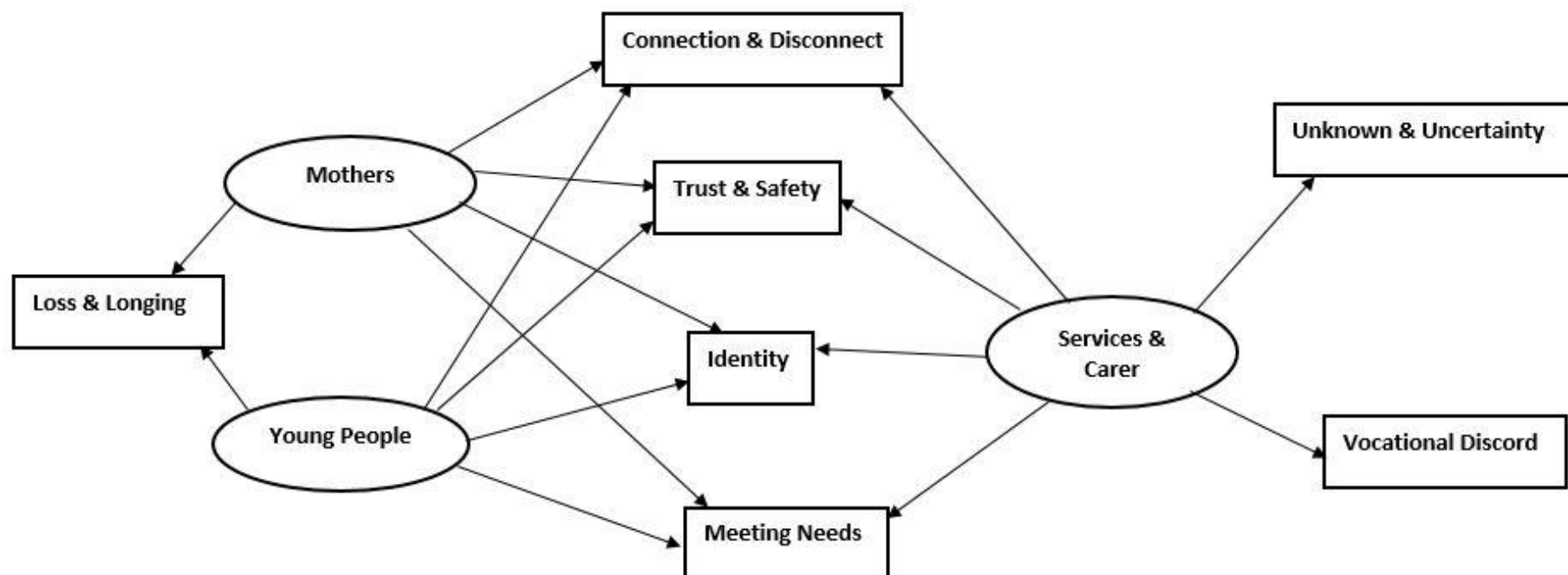


Figure 4: Cross Group Themes

As illustrated, there were four common themes across all participant groups, Connection & Disconnect, Trust & Safety, Identity and Meeting Needs. It appeared that subthemes of the studies interacted on several levels including abstraction, subsumption, polarisation, contextualisation and function (Smith et al, 2009). Young people and mothers with R/AS shared a common theme of Loss & Longing. Two additional themes emerged from the services & carer group. These themes were interlinked as Unknown & Uncertainty may have caused some of the experiences of Vocational Discord.

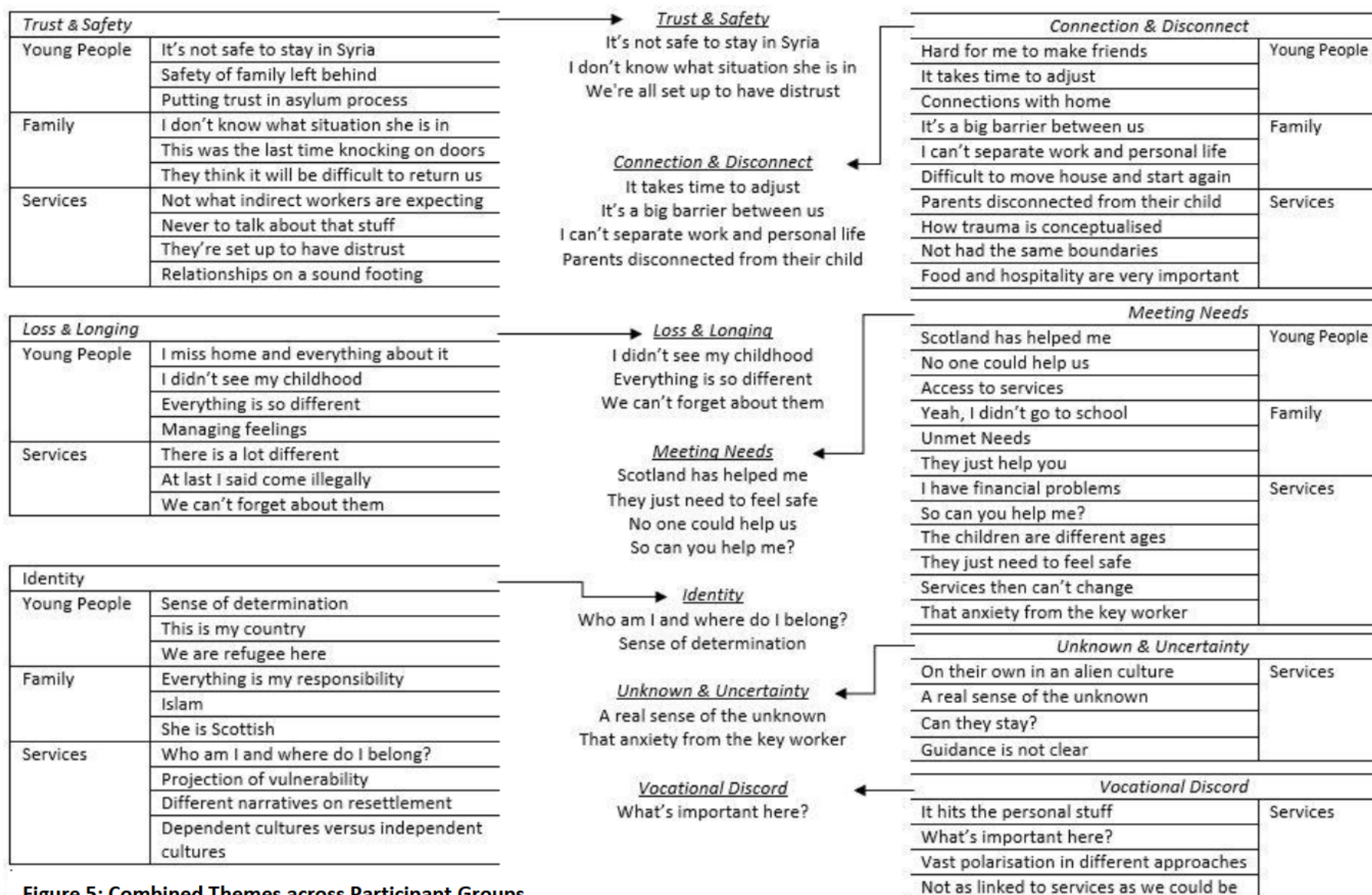


Figure 5: Combined Themes across Participant Groups

Trust & Safety

Participant groups discussed the importance of safety and trust in various aspects of their lives. This theme traversed time, whether R/AS participants reflected on their memories of home, or discussed their future safety within the UK. Young peoples' past experiences and memories understandably had an effect on their present wellbeing and outlook for the future.

It's not safe to stay

Several young people reported that physical safety was a key factor in their family's decision to leave their home country. Although young people were not specifically asked about their previous traumatic experiences, they seemed an important tool used throughout narratives, to express the emotional impact of leaving home, and to present examples of how different life had been in a war-torn country.

It appeared the immediacy of attacks and the uncertainty of safety in everyday life, left young people with a hypervigilance about their surroundings, as well as traumatic memories of dead bodies and bombed communities.

Hassan (2; 22-24) "It's not safe to stay there. Maybe don't know what time you will die too or if you walk on the street, you will find some people died" (YP)

Waseem (4; 107-111) "I was going to school when I was 10 years? I smelt ice cream and I just want to buy ice-cream and then go to school. When I arrived to the door of the school I listened and boom like bomb, and the teacher said the bomb was, they land on the ice cream. So if I late one minute I'm not here" (YP)

Lauren (19; 443-456) "He's talked about coming up through {country}, and people literally falling off the truck they were on into the desert, and this truck continuing to go, and of people dying and along the way and literally just being chucked off {...} Obviously the journey over was horrendous, the boat went down, he was rescued by the coastguard, several people weren't, and that's the experience of all of these lads is people in the water dead around them" (S)

Others expressed concern if they were to return home in the future, due to governmental regimes and coming of adult age, highlighting the ongoing fear for physical safety.

Saad (5; 152-153) "I'm not back in Syria never, not after three years which mean I'm 18 years, I can't back in Syria because take me in police" (YP)

I don't know what situation she is in

All R/AS participants knew relatives and friends who had been killed in the conflict and understandably, concerns about the safety of their families weighed heavily throughout narratives.

Many people had tried to leave the country but were unable to due to financial difficulties, illness, and issues with asylum-seeking.

Hassan (6; 102) “I have two sisters still in Syria. It’s hard to come to here, they can’t, they would like but they can’t” (YP)

Fareda (6; 171-173) “I’ve got a daughter. She’s in Aleppo, she’s still there. She was in Lebanon also, but they told her that you have to go back to Syria” (M)

In some cases, participants expressed uncertainty at the potential danger their families may be in, whilst others knew that their relatives were in immediate danger. Participants learnt of attacks through the media, leading one mother to rely on faith to keep her family safe.

Fareda (6; 199) “{Mum} is in Idlip, and Idlip is being bombed {silence} God bless them” (M)

More generally young people felt a sense of empathy and compassion for those left behind, having had some experience of what they were currently going through.

Waseem (7; 233-238) “At home in Syria, I’m really sad when I saw that, videos, children are dying, I don’t mind for the older people, because they saw their life, but the children they saw nothing. No life and they have no blame, like me” (YP)

We’re all set up to have distrust

Regarding ongoing safety, young people commented upon the difficulties of the UK asylum process. All the young people had arrived in the country through the VPR Scheme, therefore meaning that they had been granted refugee status before arrival to Edinburgh. This minimised the feelings of uncertainty and insecurity once young people were in the country, however participants were given little knowledge about Edinburgh before arrival. Hassan, Amira and Waseem all commented on the uncertainty around their journey; not knowing where they were going. Having to put blind trust in an unknown government was hypothesised to have created difficult thoughts and emotions.

Hassan (4; 75-77) “Just difficult when you travelling to here because we don’t know where we are going so that’s why. We know we are going to Britain but to where we don’t know” (YP)

Waseem (4; 133) “when I was in the airport I move around a lot, so I feel like, nervous” (YP)

Staff participants spoke of their experiences of supporting other young people through the asylum process, with regards to the importance of being believed, the arduous nature of Home Office assessments and the impact of the process on families’ mental health.

Service 1 (4; 106-117) “They can’t quite fully process it because they don’t quite know what’s gonna happen yet, and it almost feels like there’s a before, during and after kind of time, where you’re waiting to have the thing happen, and then you get the news about what it is and then you have to process that news {...} I suppose it’s like walking that journey with them is really hard, you don’t know what the time limits are or when the next step will happen or not” (S)

Service 2 (5; 127-132) “that temporariness of you are allowed to stay but it’s only for a set period of time and then it’ll be reviewed. There’s a real kind of an injustice of some people get to stay and some people don’t and alongside that, there’s a sense of people having to tell the story that allows them to stay, which at times muddles up their actual story because they’ve been given advice about what you need to say to stay, but then their own story might be just as bad and just as painful and just as awful” (S)

In particular, Lauren (carer) spoke of her frustration at witnessing her foster child being put through asylum interviews and how this may have retriggered many of his traumatic memories.

Lauren: (14; 326-345) “the asylum process, that was murder because he had to keep going and telling his story over and over again {...} I remember one time of her saying ‘but you said last time that they hit you on the back of the leg and now you’re saying the front’ and I’m like ‘really?! Look at his legs, his legs are covered in scars so it was probably the back and the front from what I can see! But it doesn’t matter, does it matter that much?’ And she said ‘seriously, these are the things they try and catch you out on when you go for your Home Office interview’ {...} I was thinking ‘God how to re-traumatise someone’” (S)

Participants also commented on the difficulty of obtaining asylum or refugee status for family members. The UK government’s decisions were a cause of concern for families, as in one example, Saad’s cousin was not able to gain asylum due to a criminal record, from a country where many refugees consider the government and police force as corrupt.

Saad (5; 171-173) “It’s hard is coming here, it’s so hard. My cousin need come here. If doesn’t have any problems, you can come here, at first time and quickly. If you have like problems like him, hit anyone in their countries, then like it’s so long for coming in UK” (YP)

Even when granted asylum, R/AS participants reported that the UK had extremely strict rules about family visits. There appeared to be distrust from authorities over their motives and a fear that refugees would break the law and encourage their family members to remain illegally. A sense of betrayal and frustration at the government’s distrust appeared evident from participants.

Aisha (8; 238-240) “To the UK is very difficult, because she is refugee. The government here does not allow refugees for visiting, because they think it might be very difficult to return them. And they would live like as refugee here, but they wouldn’t you know” (M)

Literature regarding Trust & Safety

There are widespread reports of the atrocities experienced by civilians living in a war-torn communities, and the impact of these on emotional well-being (Miller et al., 2008; Kadir, Shenoda & Goldhagen, 2019). Cross-culturally, children display a need for safety and predictability from a young age, reacting with distress and anxiety if this is not met (Maslow, 1943; Tay & Diener, 2011). Theories regarding safety and stabilisation suggest that young people may not be able to accept and process previous traumatic events whilst simultaneously living in a dangerous environment, in a constant state of arousal (Herman, 1997; Silove, 2005).

Issues of trust and safety may also apply to young people currently facing uncertainty with the asylum-seeking process and a fear of having to return to a traumatic environment in the future (Stewart & Mulvey, 2014; Carswell, Blackburn & Barker, 2011). There is a sense that the asylum-seeking process can be unpredictable and unjust regarding who is approved to stay in the UK, as evidenced by the large number of successful appeals; 44% of initial decisions were overturned (Home Office, 2019). As a result of the extensive literature-base surrounding the importance of safety and trust for R/AS families (Henley & Robinson, 2011; Pacione, Measham & Rousseau, 2013; Schaal & Elbert, 2006; Bayer, Klasen & Adam, 2007), and the impact of the asylum process, (Stewart & Mulvey, 2014; Jakobsen, DeMott, Wentzel-Larsen & Heir, 2017; Schock, Rosner & Knaevelsrud, 2015; Li, Liddell & Nickerson, 2016) this study will not cover this topic in detail.

Young people and mothers also expressed feelings of helplessness, anxiety, guilt and shame at leaving loved ones in danger, potentially having a negative impact on their ability to integrate into host communities (Refugee Council, 2018; Goveas & Coomarasamy, 2018). Current UK laws allow the application of reunification schemes for families of adult refugees, but not child refugees (Scottish Refugee Council, 2020). This can be particularly devastating for unaccompanied minors who are prevented from sponsoring their families to resettle in the UK. Fear for families was found to be a higher predictor for poor mental health than effects of previous trauma or resettlement stressors (Nickerson et al., 2010). Young people also reported checking for news of ongoing conflicts, looking for attacks near known locations, in an effort to gain information. It may be that this fear for their families, accounts for the poorer mental health associated with ongoing conflict in a home country (Porter & Haslam, 2005).

Connection & Disconnect

R/AS participants described reduced connection with their home country (explained further in *Loss & Longing*) but also a sense of disconnect with their new communities in Edinburgh. There appeared to be an acceptance that this disconnect would be present as they adjusted over time. There were also clear attempts to build relationships in Edinburgh, whilst also preserve connections with home.

It takes time to adjust

There was an acknowledgement from young people that adjusting to life in Edinburgh takes time and effort. As part of this adjustment process, three young people and one mother described spending the first several months with their families at home. This changed over time, with families initially relying on support worker involvement before gaining more language and knowledge about their surroundings.

Mohammed (6; 109-110) “First I stayed at home doing nothing, I wasn’t speak never English, maybe 2 or 3 months. {It changed} when I knew more about what life in here, about what people think. It just takes time yeah, it just takes time” (YP)

Sabah (12; 386-388) “I stayed inside my house for 3 months when I first arrived and did not want to go outside. I told my husband that I did not want to stay here, I want to go back to Syria. Now it is better but I missed my family and my home. Now I miss Edinburgh when I go on holiday” (M)

Aisha (9; 286-293) “When we first arrived, it was very difficult, the first three or four months, even year. And at the school and in the class, it was very difficult for him {son}. When you first arrive to a new class and you can’t really get others, it’s very difficult. Now they are very close friends {...} he wants to stay at the same school” (M)

Despite this necessary adjustment time, there were common experiences of being moved into different houses once settled in Edinburgh. This made it even more difficult for families to integrate with the community when there was a temporariness to their stay. There is a potential for triggering traumatic memories of fleeing their home country. Mothers also voiced concern about the areas they would be moved to, for fear of racism. It also affected young people’s educational and social opportunities, as Saad reported.

Service 3 (3; 90-96) “They’ve been in temporary accommodation for 4 years, they’re moving to another area of the city to another temporary house which I’m very cross about, so I’d question well, why have you done that? They’ve roots in this area, the children are now speaking with a Scottish Leith accent and they’re moving again so not sure they’ll be part of the group here anymore. They had a very short notice to leave their house and to move into the next temporary house. Well it’s almost like replicating isn’t it, almost at an unconscious level, the moves at short notice and in an unplanned way you know?” (S)

Fatima (12; 375-377) “Especially when you get your area and your neighbour, and everything around you, your house, that makes it very difficult to move to the new house and start from the beginning again” (M)

Saad (2; 50-51) “It was hard for me because I moved to lots of schools, I changed about six schools” (YP)

It’s a big barrier between us

All six young people reported difficulties with making friends in Edinburgh, citing language and multiple school moves as potential barriers. Amira in particular reported her struggles with making friends in school, being exposed to racism and bullying.

Amira (9; 228-230): “Every single day, when I went home from school, I used to cry because I didn’t have any friends and I didn’t understand anything they were saying to me. They were just saying stuff to me, swearing at me, telling me to go home, not sitting beside me in class, just because I couldn’t speak English” (YP)

There was a sense of disconnect with Scottish community from both young people and mothers, not understanding the language but also culturally why friendships felt more difficult. Young people discussed feelings of frustration and anger when trying to speak to school friends. They appeared to feel isolated and viewed themselves as different and separated from the host community. Mothers wondered about the impact of racism and Islamophobia on people’s willingness to befriend them, leading the R/AS community to also hold back from approaching neighbours.

Saad (3; 100-102) “When you do to any country different from your country, you say like tsk I’m not same these people. Yeah I’m saying this that is my feeling” (YP)

Aisha (1; 57-65) “I don’t know that they feel that they are afraid or scared because of Islamophobia. {...} Someone told me that my neighbour next door is sick, and she is not feeling well. I knocked on the door to just say hi, how are you, do you need any help? And she said no, you can’t come in here, (*gestures with hands in front of her, palms displayed*) and this was the last time knocking on the doors” (M)

It appeared that young people used a variety of methods to create social groups within the host communities.

Amira (10; 273) “I do basketball but I do it within the school so I’m part of the Scotland basketball team” (YP)

Ahmed (3; 83-88) “All my friends say join rugby, you know be better at rugby. So I say, ok I’m just gonna join rugby and actually, rugby made me to communicate more with my friends” (YP)

From the perspective of services, there was a recognition of the importance of building connection and trust in relationships with the refugee community. Staff reported that the cultural differences between the local community and R/AS families resulted in alternative methods of engagement.

Service 3 (6; 168-173) “if you come in with a very boundaried, statutory way of working then you’ve got to be more flexible, and that might mean going into the house, accepting offers of food and almost being seen, although you know you’re not a family friend, but being seen as a family friend and that’s the way to engage, so it’s not saying there isn’t a professional boundary, we’re aware of it, but it’s a looser, more fluid boundary and being comfortable with that” (S)

Service 2 (8; 187-197) “Trust is such a big thing and you need to be believed by the Home Office and so trust is really important, then it’s hard for residential staff to do the ordinary checking in that you would do with an adolescent, so have you been where you said you were? {...} People get caught in that no-man’s land about what to do with that ordinary stuff that’s part of ordinary adolescent development” (S)

I can’t separate work and personal life

Services expressed concern at the welfare of support workers, volunteers and interpreters working with R/AS families, citing their lack of support and a build-up of multiple distressing stories.

Service 1 (2; 36-40) “someone was provided to give him special help to learn English and then that person became his confidante, completely understandably. So that person was having to deal with the child’s trauma and memories of explosions and bombs and losing their homes and all that. And so that was really tricky because that wasn’t what he’d bargained for” (S)

Service 1: (7; 200-213) “We’ve got no idea what their (interpreters) experiences may be and what experiences of their own that they might bring into the room. And I’m imagining that with some of the refugee families that must be incredible. Because that might be the same interpreter working with quite a few refugee families and you might wonder if they’re feeling... from some of the more gruesome aspects of therapy sessions {...} This one interpreter takes on everything, and how they manage to keep that separate themselves I don’t know. And they have very limited support so there’s concern there I think about what those interpreters are left with” (S)

It seems that workers may be caught in the middle of two worlds (personal and professional), unable to connect or disconnect fully with either. As evidenced in the mothers’ interview, the interpreter described instances where she found it difficult to maintain professional boundaries with a family she had interpreted for.

Sabah (10; 328-331) “Some families, when I go and do the interpreting for them, I have to contact them from my phone. They can save my number easily and I only got one mobile number so I don’t separate numbers. One day, one of them, just an unknown mobile number phone me at 11 o’clock at night” (M)

Additionally, during the focus group, she reported the desire to share her own experiences with the researcher, as they linked so closely with the other participants in the group, further indicating that it may be difficult for interpreters to disconnect from their work.

Sabah (10; 325) “it’s hard after 5 o’clock, because you know here, honestly, I will tell you about my experiences, I want to share it with you” (M)

Literature regarding Connection & Disconnect

Cognitive theories of adjustment suggest that sudden life changes can shatter prior schemas and lead to anxiety and distress related to an inability to predict and control aspects of everyday life (Janoff-Bulman, 1992; Newsome & Kendall, 1996). With R/AS families, these huge shifts in circumstance and the challenges to prior beliefs about the world are exacerbated by an inability to trust previous schemas, due to the vast differences in culture, family dynamic and community infrastructure. The inadequacy of prior schemas can overwhelm individuals, leading to a withdrawal from the host society while new schemas are created (Kendall & Buys, 1998; Nishida, 2005). Participants spoke of needing several months before beginning the process of integration, and attempting to connect with the Edinburgh community. Additionally, after the initial adjustment phase, many refugees in Scotland are required to move to multiple temporary houses (Home Office Affairs, 2018). Secure housing has been found to be of central importance for families’ well-being and feelings of safety and belonging (Credland, 2004). Multiple moves, without warning or support could lead to difficulty integrating into the local neighbourhood, having to readjust to new environments and social communities (Ziersch, Walsh, Due & Duivesteyn, 2017). Within this context, adjustment becomes a lifelong transition rather than a time-limited process (Nishida, 2005; Fazel et al., 2012).

Ager & Strang (2004) identified three types of social connection; social bonds (with similar cultural groups), social bridges (with other communities) and social links (with public services). The different types of connection independently affect R/AS perceived quality of life, and therefore all are key to effective integration (Ager & Strang, 2004).

- Social Bonds: The importance and maintenance of social bonds is discussed in *Loss & Longing*.
- Social Bridges: Given the importance of social bonding in collectivist cultures, many refugees associate frequent social contact with a sense of belonging, something which may be considered overwhelming in individualistic cultures (Safak, Kunuroglu, van de Vijver & Yagmur, 2020).

Studies have emphasised the importance of building social networks for R/AS families to feel connected to their host community (Beirens, Hughes, Hek & Spicer, 2007). It can also build self-

esteem and confidence, a sense of identity and improve feelings of isolation (Smeeke et al., 2017; Sierau, Schneider, Nesterko & Glaesmer, 2019). Feelings of isolation and loneliness can undermine mental wellbeing and the negative effects can be cumulative. It can lead to barriers in accessing much-needed support due to lack of awareness about services and a distrust of others (Quinn, 2014). Participants expressed a strong desire for social connection with their host community but often felt distrusted or rejected. Strang and Quinn (2019) found that fewer than half of the refugee participants in their study reported having contact with a Scottish friend in the past six months. As evidenced with the participants' experiences, integration and social connection is a two way process; which needs to be facilitated by both the refugee and local communities (ECRE, 1999; Miller et al., 2002). Both parties have recognised the significance of small acts of daily friendliness and valued neighbourhood support (Ager & Strang, 2004; Woolcock, 1998).

- **Social Links:** Services recognised the importance of trusting relationships to reduce barriers to accessing services for R/AS populations. In line with Ager & Strang (2004), Service 3 reported the need for services to be more proactive at engaging the R/AS population than they may be with local communities, due to families' unfamiliarity with Edinburgh. This may fit with a flexible engagement model, as outlined by Bang & Finlay (1987) or Marlowe (2010). Difficulties that have arisen with supporting R/AS young people and their families is explored in *Unknown & Uncertainty* and *Vocational Discord*.

Finally, the theme of *Connection & Disconnect* touched on the lack of support for interpreters, volunteers and support workers. Studies have found significant rates of secondary trauma and experiences of burn-out within care-giver and interpreter populations (Kindermann et al., 2017; Denking et al., 2018). The interpreter for the mothers group was a refugee herself who had moved to Edinburgh several years previously. There is some evidence to suggest that workers with a refugee background or exposure to violence may be more at risk to developing mental health difficulties than host community workers (Miller et al., 2005; Lai & Mulayim, 2010). Some strategies used by staff including humour, distraction, substance misuse and self-blame were considered maladaptive and associated with negative outcomes (Akinsulure-Smith, Espinosa, Chu & Hallock., 2018). Resilience when working with R/AS populations was linked to secure attachment style, high emotional intelligence and a strong support network (Kindermann et al., 2017; Denking et al., 2018). Research provides suggestions for employers, including reduced caseloads, increased and meaningful supervision, peer support, and professional training regarding cultural sensitivities and self-care (Akinsulure-Smith et al., 2018; Kindermann et al., 2017; Mirdal et al., 2012).

Loss & Longing

Both R/AS participant groups shared experiences of extreme loss. For some, this theme captured the loss of family and friends, whilst for others, it represented a loss of childhood and opportunities for the future. Ultimately, this resulted in feelings of longing for previous lives and familiarity. Attempts to reconnect with what participants had lost were impeded by extra responsibilities and lack of resources.

I didn't see my childhood

Mothers reported that the impact of resettlement was influenced by the age of their children.

Fatima (10; 310-311) "Because my children are small age, they don't understand but her son {Aisha} was twelve years so he missed his cousins, it was very difficult for him" (M)

All young people had experienced traumatic losses and witnessed violence against their loved ones. Several participants reported having multiple jobs from childhood and having financial responsibilities towards their families.

Saad (2; 65-70) "I start job in like at 7 years old? {...} I go with my Dad in supermarkets and I go with my uncles. Then when I go to Jordan, I go to job to café, I make tea, coffee. I job everything" (YP)

Hassan (7; 128-130) "Yeah 12 {years old} I have three jobs actually. I am a tiler and a barber and I make Arabic food, like a chef" (YP)

This meant that the majority of young people had missed significant amounts of education. Many spoke of a longing to be in school and gaining qualifications for their future.

Service 3 (15; 439-444) "The children have missed schooling, how behind they are, they've picked up spoken English very quickly and how a lot of the children are very bright, and clever but their written English and ability to read and write is almost at P1 level, and these are children who are in early secondary school and they might have ambitions to achieve or to do things but they've been held back by that" (S)

Waseem (2; 40-41) "when I saw the children were out of the school and I can't go there (*tearful*), it was really sad and hard" (YP)

Ahmed (2; 58-63) "from P3 to P6, I didn't have any education, we did go to school {in refugee camp} but it wasn't a school {...} the school was like the tent was like ripped and like just the cold, the cold wind just hit you and yeah that was during school, that was bad (YP)

Hassan (6; 114-117) "I was exciting because I never study in Syria, I have like ambitions to study, I was very happy that I come to here, so I can continue studying" (YP)

Both Waseem and Ahmed described the loss of their childhood and emotional impact of this realisation. Young people recognised that they should have had the opportunity to play and learn at this stage of childhood. Ahmed expressed the feelings of hopelessness that the loss of his childhood would lead a loss of his future, perhaps due to a lack of educational opportunities.

Waseem (1; 35-36) “I worked cashier, cleaning toilets, because I was so younger, so they can’t let me to work and I just told them, anything I can work and just to help my family (*tearful*) so they give me really low money” (YP)

Ahmed (5; 121-125): “You know P3 like to play until P6 or P7, they still want to play, so we didn’t see much of that, so you know that’s quite... So back there I said OK my future is gone, its hard you know, when I’m small, I am person who says (*sigh*) my future is gone, so you know I didn’t see my childhood so much” (YP)

Young people expressed a sense of longing to return to their relatively carefree childhood. There were attempts to reclaim some semblance of their lost experiences, although participants acknowledged that they were now subject to appropriate developmental responsibilities, such as studying.

Waseem (5; 145-147): “You know when I come here and I saw the park where the children playing, you know I went there and I play, because I have no other play when I was child” (YP)

Ahmed (5; 125-126): “Now you know we got to this age, we want to go out and to have a good life, but then you need to like study as well. The studying is can stop us, not like P3” (YP)

Everything is so different

There was a sense from young people and mothers that the sheer difference between their previous lives and their experiences in Edinburgh had a big impact on their ability to resettle and adjust. Young people appeared to feel overwhelmed by how much they had to learn about the language, culture and even infrastructure of Edinburgh. Services also acknowledged the difficulty of this for families.

Saad (1; 35-36): “Different for roads, cars, buildings, countries, people, speaking language, all of them difference, yeah schools” (YP)

Service 2 (5; 110-112) “These are young people who are completely on their own in an alien culture so not having any points of familiarity has a much more significant impact, and I don’t think that that can be underestimated” (S)

Young people were required to adapt to a completely different lifestyle due to the weather whilst mothers spoke of the cultural differences in even the ways that communities interact.

Mohammed (2; 29-30) “It was always like hot and 47 degrees, something like this. I get white now, (*indicating bare arm*) I didn’t used to stay at home all the time. Yeah I was in Jordan like that {always outside}” (YP)

Aisha (1; 54-57) “People are friendly in different ways. In Syria there are doors always open. But here, no. Here you can’t. For example in Syria you have neighbour, you will just knock on the door and go inside, have coffee, tea, food together. Here is completely different, you have to get an appointment or that” (M)

The loss of familiarity led to attempts to reconnect with their home culture. The R/AS community in Edinburgh helped two participants to preserve connections with their Kurdish ethnicity. Attendance at the mosque allowed for social connections with other Muslim young people, and peer relationships were fostered in R/AS youth groups. Additionally, all the mothers in the focus group had met in the charity group from which they were recruited.

Amira (10; 269-270) “We used to have a Syrian group like teenagers, we used to go to Spartans, it’s the football club” (YP)

Lauren (26; 368-369) “They {mosque} did run a youth club initially for a few Saturdays, they’d go to something up there” (S)

Food became a key topic throughout interviews, with young people commenting on their desire to maintain their previous diet. It is hypothesised that food represented a concrete connection to cultural identity and loved ones left behind. Amira, in particular described her mother’s various inspirations and recipes whilst Saad spoke of his family’s desire to cook as they had in Syria.

Amira (7; 182 & 8; 197-198): “And the food. I don’t like the food (*laughter*), I don’t like trying new foods, it just doesn’t have the taste” “Mashi, which is, you get grape leaves, aubergines, stuffed with rice and you have meat on top of it, they are amazing” (YP)

Saad (5; 144-146): “My family, they like food Arabic, they still like cooking for that. I say do anything for food Scottish, they say I can’t do it, only Arabic” (YP)

Services and Lauren (carer) attempted to acknowledge the importance of food culture within the R/AS population. Efforts were made to cook familiar foods, and sharing meals became important group activities.

Lauren (2; 54-61) “How do we make sure we’re feeding him what he would like to eat and I can do stuff that’s even semi similar to what he might have at home so I looked up recipes and menus {...} so we had to order a particular spice, berbere, which is a particular Ethiopian spice. It has to be halal so taking him off to this halal butcher” (S)

Service 3 (7; 192-208) “In Islam, they say that you should treat your guests as if they’re the Prophet Mohammed and therefore hospitality is key and feeding your guest {...} Food is important and retaining culture when people arrive here, so the Mums group, I mean cooking food, and eating food together and being together with food, that’s about caring what they’ve brought from other places and sharing that in a reciprocal way” (S)

We can’t forget about them

Participants expressed a loss of relationship with family members; having been young when they left, that they could not remember some relatives, but also a loss of the relationships that could have been, if they had had the chance to grow up together. There were long silences during interviews when young people and mothers discussed missing their loved ones. Young people reported that they had had no sense of closure or a chance to say goodbye to family.

Ahmed (4; 108-111) “When we moved my grandmother was sick (*sigh*) so it was sad for us we didn’t have time to see her. I still haven’t seen my grandmother, well my family for seven years. There is some family that, I don’t know them and that’s quite hard” (YP)

Amira (2; 53): “Like I’ve even forgotten who I was friends with, I just remember some things but, not very much” (YP)

Lauren (7; 157-159) “for a young lad who would be about to get married, probably in an arranged marriage if he was back home, so having to think about how tricky some of that is for him” (S)

Most participants talked about keeping in contact with their relatives by phone or email. Although this helped families to stay up to date with family news, many commented that there was still an element of disconnect.

Ahmed (2; 49-50) “I felt sad, so it was really far from family and my friends. We do speak to them yeah but it’s not the same, different to call them on the phone to see them” (YP)

The strength of the familial bonds appeared to make separation even more difficult for families, exacerbated by concerns for their safety (discussed in *Trust & Safety*). Participants expressed an intense longing to see family and friends.

Fareda (6; 176-179) “even by visa or something like this. We don’t mind to pay or something like this, the important thing that we want our family to be close” (M)

Aisha (6; 184-186) “I was telling my son, come just come, and at last I told him just come by illegal way or just smuggle, and he came by legal way (*laughter*) thank God” (M)

Sabah (7; 226-229) “It affects yeah. Of course if you have your sisters, brothers round you. Our communication is very strong, and for that reason, yes. We can’t forget about them. Our culture is like this” (M)

Lauren shared an extremely poignant moment where her foster child was able to find and speak to his family after multiple years of uncertainty and no contact.

Lauren (32; 769-784) “He found his mother on Facebook {...} and us all sitting there watching when he gets through to his mum and then thirty minutes of him holding back tears and we could hear him telling her about the journey he’d made, naming {countries} and Edinburgh and then looking up every now and then to say that his mum was thanking us for his bed and thanking us for his education and us trying to hold it together when it was really making conversation four years down the line with his Mum” (S)

Additionally R/AS participants often had very little notice about their departure, having to flee their homes quickly. Many became, understandably upset and tearful when describing the losses they had faced, including material possessions. These discussions appeared to represent a loss of status and dignity, but also the loss of a life that could have been. Waseem captured the feelings of sheer helplessness that families felt over their abrupt and uncontrolled departures.

Waseem (3; 98-103) “They told us you have 48 minutes to go out because we were bombs the city (*tearful*) and we don’t have car because my father, he lost it and we can’t go out and stay in home. Then the 48 minutes is done, is gone like. The war is started the homes, and we didn’t know how to go out, we cannot run, we can’t do anything {...} so we lost everything, home, cars, everything is like gone in the war and there is bomb so everything gone. So my father was lawyer, we went to Lebanon, he works like taxi, like we were not rich but we had money, but when we lost everything, I was so sad” (YP)

Literature regarding Loss & Longing

Theories of grief may be applicable to the losses experienced by the R/AS population. The stage model of grief is widely documented; denial, anger, bargaining, depression and acceptance (Kubler-Ross, 1969; Maciejewski, Zhang, Block & Prigerson, 2007). Alternatively, Stroebe and Shut (2010) developed a dual process model; individuals alternate between loss-orientation mode and restoration-orientation mode where emotion focused and problem focused coping strategies are used respectively. It must be noted however that Western theories of grief may be of limited value when exploring the experience of loss in other cultures (Bhugra & Becker, 2005).

Collectivist cultures put emphasis on the wellbeing of a community as a whole and depend upon interpersonal connection (Liu, Morris, Talhelm & Yang, 2019). Within collectivist cultures, this loss of

family relationships may be felt more keenly than by those in Western cultures. The ambiguity of loss related to family members left behind was related to the lack of certainty regarding loved ones' wellbeing and/or potential reunification (Boss, 2004). Unfortunately this means that R/AS young people and families are unable to participate in traditional mourning practices which may help to process their loss and associated emotions (Luster et al., 2008). Alternatively, as with Lauren's foster child's experience, it may be that R/AS individuals are encouraged by the hope of seeing their family again (Luster et al., 2008).

During particularly difficult narratives about the loss of contact with loved ones, both young people and mothers became tearful and fell silent. It was hypothesised during these moments that participants were unable to find the words to describe their grief, or weren't able to talk about their loss for fear of becoming overwhelmed (Ghorashi, 2008). Alternatively, grief therapies suggest that silences when discussing loss could represent unspoken memory; preserving a person's memory by withholding the narrative of the deceased (Baddeley & Singer, 2010).

Both young people and mothers also reported the loss of familiarity regarding culture, support networks and opportunities. Cultural bereavement is defined as "the experience of the uprooted person or group resulting from loss of social structures, cultural values and self-identity: the person or group continues to live in the past, is visited by supernatural forces from the past while asleep or awake, suffers feelings of guilt over abandoning culture and homeland, feels pain if memories of the past begin to fade, but finds constant images of the past intruding into daily life, yearns to complete obligations to the dead, and feels stricken by anxieties, morbid thoughts, and anger that mar the ability to get on with daily life" (Eisenbruch, 1991, pp. 673). Theories regarding cultural bereavement stress the importance of individuals using coping strategies that are traditional to their own cultures, such as the use of spiritual beliefs or mourning rituals (Eisenbruch, 1991; Bhugra & Becker, 2005). Participants in this study used food as a form of cultural continuity and to preserve social connections, something considered especially important considering the significance of food and hospitality in some cultures (Edwards, Wilson, Willingham & Christenson, 2018; al-Qattan, 2014).

The final subtheme identified in *Loss & Longing* is the participants' perceived loss of their childhood, due to a lack of education and play opportunities, and a forced independence due to financial responsibilities (Thommessen et al., 2015; Van der Kolk, 2017). The developmental stage at which young people experienced difficult events is reported to have an impact on children's grief and trauma presentations (McLean, 2016). Many participants were very young when they witnessed and experienced traumatic events, and left their home. Slone and Mann's (2016) systematic review suggested that children aged 0-6 may experience disturbed play, sleep difficulties and

psychosomatic symptoms. Longitudinally, the impact of trauma can alter the physiology of the developing brain, and predispose a young person to maladaptive behaviours, ill health and early mortality (Kadir et al., 2019; Yohani, 2015). Studies have suggested that recreational activities may be a pathway to provide experiences that young people may have missed during their childhood in conflict-countries and on their journey (Hallahan & Irizarry, 2008. Stroebe & Shut, 2010).

Meeting Needs

All participant groups discussed experiences of having their needs met and instances where support could have been improved. R/AS participants expressed gratefulness to the Scottish community. Conversely, they expressed feeling alone in their struggles and asked that more help be given to support resettlement. The needs discussed also appeared to have an impact on their emotional wellbeing.

Scotland has helped me

All R/AS participants expressed gratefulness to the Scottish government and people of Edinburgh for welcoming and supporting their resettlement. They reported positive first impressions upon arrival to Scotland and spoke of the provision of housing, financial support and education.

Ahmed (5; 138-139) “it was hard for us to read so the support workers came to our house and they did everything, all our appointments. It’s really been helpful for us” (YP)

Hassan (13; 245-247) “I give thanks for the government because they are been providing everything to us since we come to here so education, houses” (YP)

Community support from the neighbourhood allowed participants to feel welcomed and valued. Charities were also involved in supporting young people with English classes, peer support groups, practical difficulties e.g. clothing and transport.

Raheef (2; 69-70) “If someone faint or feel that there is any problem, all the neighbours run to them and say what’s going on?” (M)

Amira (8; 213-215) “{Charity} helped us with electricity and stuff at home, and how we can use them. How we can turn on and off the radiators and stuff. How to get a bus, where everything was” (YP)

Lauren (30; 723-726) “just regular folk, all being open to trying and neighbours who were teachers saying if he needs any help with biology, chemistry, let us know. People really wanting to reach out and help out and lend a hand where they could” (S)

It seemed that some young people felt an unspoken obligation to appear grateful for the support received. There was a sense that participants felt the need to praise Scotland and could not compare it negatively to their own country. Young people perceived that there were unspoken conditions to accepting refuge and they may not be allowed to stay in the UK if they had any complaints. This was also recognised by services.

Hassan (3; 43-53) "I find Scotland the best country I've seen in my life. Better than my country {...} they {family} like it here also. If they don't like it they can't come to here. We like it here that's why we stay here" (YP)

Service 2 (15; 375) "There's a need to conform isn't there? Because if you're not conforming you're not gonna get to stay" (S)

I just had to learn myself- no one could help us

Despite some support, young people and mothers reported that they felt alone with a lot of their concerns. They described examples when well-meaning help had been offered, but ultimately was not effective.

Waseem (6; 198-199) "The teachers, they can't help us because they have other students, they can't stay with us, so nobody can, nobody can help us" (YP)

Ahmed (7; 151-154) "I haven't studied science back home so it's really hard for me to understand in Arabic, sometimes my school translate like big words. But I doesn't know what it is in Arabic so I've never seen it and I've never studied so I understand English than like Arabic" (YP)

So can you help me?

Young people and mothers were able to identify unmet needs including housing, financial stressors, communication issues and lack of meaningful activity.

Ahmed (9; 186-189) "Some people still doesn't know English so it's hard for them to go to doctors The hospitals, my mum doesn't speak English so it's really hard for her because of my sister. When we say can you apply for an interpreter, so they say yes and then but then when we go there is no interpreter" (YP)

Amira (11; 288-290) "I think trying to help students who come here like teach them more English in the first instance, go to school and see how they're doing, ask them if they're doing ok, if anyone is upsetting them" (YP)

Fatima (7; 208-212) "I asked my support worker about my sister, because she wants to come here and study. {...} I have been told by my support worker that you have to go to the lawyer and ask the lawyer, so I wonder if you {researcher} can help me." (M)

The majority of needs were considered pragmatic, however, when unmet, these had a large impact on their mental wellbeing and sense of belonging within the Edinburgh community.

Service 3 (8; 230-238) "Some of the men were engineers or professionals or blacksmiths or architects and by March 2020, 500 individuals will be settled here and I think 1 or 2 of the men have jobs. If you've suffered trauma, {...} and you're sat at home in your head all day, then what is the point in developing mental health services, when you know that's a huge strain on someone's identity and sense of self. So I think housing and employment were not thought through, and I think that it should have been thought through. I know that the scheme was set up as an immediate response to keep people safe, but I think that should have been looked at with a longer term vision" (S)

Managing Feelings

Young people expressed a variety of emotions related to their previous experiences and the difficulties of resettlement. Despite acknowledging their difficult feelings, no young person reported symptoms typical of trauma reactions, anxiety, depression or other mental health difficulties. The services participant group had several theories on why this may be, including Western concepts of mental health or inadequate outcome measures.

Waseem (4; 117) "{I felt} nothing, because you know when you see the bomb every day, so you feel like it's nothing" (YP)

Service 1 (2; 48-53) "It was a lot of physical health complaints so headaches, stomach aches, eating difficulties, sleep difficulties and he had a lot of jaw pain, and the dentist was like there's nothing wrong with your teeth, its tension and stress. And I was wondering how trauma presents and how it's conceptualised in their culture" (S)

Service 1 (12; 348-354) "His hypervigilance was almost numbed out because, course he's not gonna be scared in Scotland because he had bombs in his country, so he's almost not scared of anything at all. But he probably still is really traumatised in some ways, so the measures that we have aren't particularly appropriate in bits of it, but that don't really get to the numb bit" (S)

None of the young people interviewed had heard of the term 'mental health', or had accessed mental health services. Waseem expressed a distrust of doctors, instead speaking to friends for support. Several talked about managing feelings by burying them.

Mohammed (10; 186) "Yeah but it just, maybe I don't want to talk to that and maybe it go away" (YP)

Service 2 (15; 381-382) "a lot of young people have developed coping strategies to deal with their experiences and for some of those young people it's never to go there, never to talk about that stuff" (S)

Lauren (16; 390-397) “He has compartmentalised his whole life, so there was life in Ethiopia, there was life on the road, and then there was life in Scotland and they’re so unbelievably interconnected and so the only way to actually make sense of it is to keep them in these compartments and that works for him {...} We don’t talk about that, he doesn’t need to, I don’t need to and one day he might and we will” (S)

Waseem (8; 268-269) “Oh doctors no, I don’t do them, doctors never. I have a best friend so I just talk to him” (YP)

Staff participants also expressed concern at the wellbeing of the young peoples’ parents, both in terms of accessing support for themselves, but also regarding the impact on their children.

Service 1 (3; 69-79) “the parents trauma understandably prevents these children from mixing and being allowed to do things like go out and play or anything because it’s been so unsafe for them to do that, so it’s very difficult for them to be part of their community. {...} the community that they’d were placed in, wasn’t a safe community, so the parents ongoing trauma reactions were maintained by things happening in their stairwell or in their street”

Service 3 (2; 36-40) “we are dealing with very vulnerable families and because of the strong themes of displacement and loss, trauma presentation is quite prevalent in the family, because one member of the family has PTSD, that’s going to have an impact on the other family members” (S)

Literature regarding Meeting Needs

R/AS participants expressed gratitude to the Edinburgh community for supporting them with practical aid but also through friendship and welcoming attitudes. This was perceived to be sincere, however there may have been an underlying context of obliged gratefulness (Schwöbel-Patel & Ozkaramanli, 2017; Nayeri, 2017) Narratives of other refugees expressed similar expectations for them to posture gratefulness towards their host communities (Marlowe, 2010; Nayeri, 2019). R/AS individuals have also expressed a reluctance to discuss the positives of their heritage and culture compared to their host country, for fear of ridicule or perceived ungratefulness (Marlowe, 2010). They report that host countries can often view their home countries as uncivilised and primitive, with host countries then inhabiting the role of saviour or hero (Nayeri, 2019; Gaywood et al., 2020). Studies have previously documented instances of staff asking for acknowledgement and feelings of gratefulness from R/AS families (Tobin & Campbell, 2016; Gaywood et al., 2020).

All participant groups identified practical needs such as permanent housing, financial security and clarification regarding legal processes. Unsurprisingly, these needs could be linked to feelings of safety, belonging and emotional well-being for R/AS families (Maslow, 1943). It is argued that the post-migration stressors can be as influential to R/AS mental health as pre-migration and journey experiences (Pernice & Brook, 1996; Gorst-Unsworth & Goldenberg, 1998). Multiple models of

integration and resettlement have been developed; however there are barriers to accessing services and difficulties with providing effective support (Silove, 2000; New Scots Strategy, 2018). R/AS participants reported a lack of awareness of services but also expressed a distrust of some professional disciplines (Ager & Strang, 2004). Similar to Strang & Quinn (2019), mothers had some connection with lawyers through the asylum process, council and support workers through the VPR Scheme, however there appeared to be limited awareness of mental health services or any other public services. The study objectives were to explore the lived experiences of R/AS resettlement rather than providing an evaluation of services, however suggestions for improvements by participants have been described in Discussion.

Participants described a variety of emotional reactions to their experiences. Maladaptive reactions to difficult experiences within the R/AS population are common, where approximately a third of children presented with symptoms after resettlement (Bronstein, Montgomery & Dobrowolski, 2012; Betancourt et al., 2012). It is argued that the Western understanding of trauma and its reactions may not fit the experiences of many cultures (Measham et al., 2014). Instead, individuals often present somatic symptoms such as headache, toothache and chronic pain, perhaps highlighting the importance of establishing good contact with a GP upon arrival (Summerfield, 2001; Measham et al., 2014). No young person within this study had received CAMHS support and they reported several coping strategies that allowed them to maintain everyday functioning. Research has previously noted distraction, false bravado and suppression were major coping strategies for R/AS young people (Goodman et al., 2004; Alzoubi, Al-Smadi & Gougazeh, 2006). Others suggested a normalisation to violence and trauma so that it no longer affected them in a way unrecognised by Western frameworks (Maclure & Denov, 2006). Clinicians described the role of familial trauma on maintaining children's mental health difficulties; research has shown parental functioning and family environment as a moderator for exposure and outcome association for children (Slone & Mann, 2016; Dalgaard, Todd, Daniel & Montgomery, 2016). Whilst this was not something that emerged explicitly in the R/AS interviews, mothers did speak of difficulty adjusting to their losses and resettlement stressors, with symptoms of withdrawal and sleep difficulties.

Identity

Identity was discussed with regards to the adaptive nature of young peoples' identities and how these were influenced by migratory journeys and resettlement experiences.

Who am I and where do I belong?

Young people and mothers discussed forms of identity within the context of geographical location, religion, refugee status and age. As discussed in *Loss & Longing*, there appeared to be a sense of loss regarding the adult identity young people could have had in their home country. Some young people wanted to know more about their national identity, whereas others discussed their desire to leave this part of their identity behind.

Mohammed (8; 143-144) “I know not much about it {Syria}, so I just like to know more. It is still my country. Because I was come from there, I was born there” (YP)

Hassan (18; 353-355) “I will come back there for visiting, no more, because we have a new life here. My life is finished in Syria. I don’t have something to do there, nothing to do there. I don’t have ambitions there” (YP)

Generally, participants viewed resettlement as additive to their identity. Young people also reported changes in their goals, as their circumstances and therefore identity changed.

Saad (2; 79) “I love very Jordan. I say it is my country too, same thing in Scotland, this is all my countries” (YP)

Amira (10; 264-266) “I am from Syria, I am Kurdish. Now I just go out like a normal English person because I can understand everything, I know where everything is, I made loads of friends” (YP)

Waseem (3; 71-76) “when I was child, I was just getting my money, I want to be a rich man, I want to be like that. When I come here, I feel really good because I go back to studying, I will have degree {...} I don’t want to be rich, I want to do like degree and to do some job” (YP)

Conversely, there seemed to be attempts by some young people to distance themselves from the preconceptions of refugee status. They took care to normalise the help received, reporting to the researcher that it was not just refugees that received support. It was perceived that young people were also communicating that refugee status was not the only aspect of their identity.

Mohammed (5; 82) “I think from all the world people come to here because lots of good jobs in here” (YP)

Saad (6; 197-199) “Scotland has helped me for everything, like not just me, like all the people, same you, me, not just the Syrian people, all that has lived here” (YP)

Additionally, the age of young people in the study meant that many participants were facing developmental changes and questioning their identity in terms of increasing responsibility and

approaching adulthood. This was anticipated to have an impact on young people's resettlement experiences.

Service 2 (6; 150-153) "The normal teenage processes of who am I and where do I belong and how much do I conform to my parents expectations and how much do I rebel against my culture and actually all that becomes more complicated if you've got that extra layer of misinformation, language barrier, lack of trust" (S)

Of concern, there were incidents where one could argue that the Home Office asylum assessment had a negative effect on identity. Where individuals felt the need to tell specific stories to receive asylum, there were instances of rejection, uncertainty and distrust.

Service 1 (4; 116-119) "one of the things that comes into that is belief about age because they come in around 15 years of age and the Home Office often does checks and assessments around that so they're potentially not feeling believed." (S)

Service 2 (5; 134-139) "there's one boy in particular who told everybody that he was homosexual and that he would be absolutely hounded if he returned back to his home country, and he's not homosexual but that's what he thought would let him stay, and he couldn't just say the real reasons, and how he lived with having to tell these stories" (S)

Sense of determination

Throughout the interviews, participants exhibited a sense of determination for a better life.

Education was extremely important for all young people, as a pathway to future opportunities. Many young people worked extremely hard to learn English and advance in their school subjects.

Lauren (39; 950-953) "I think our immigration systems doesn't recognise that we've got the cream of the crop, we've got kids here who are physically fit, mentally well, strong, cognitively intelligent and actually bright so these are the kids who've made it through horrendous sets of circumstances" (S)

Amira (4; 104-107) "A scholarship, so they invited me to school for an interview, and the teacher told me I should take the entry exam. I passed it. I was pretty proud of myself" (YP)

Waseem (1; 51-53) "So I just study every day in my home, I want a new life, I want to study, I have to study cause that's the important things my life, yeah, I want to do that future?" (YP)

Saad (2; 57-60) "my friends say, how can you do is very hard for you cause you not have language or school before, I say its fine, everyone is focused and will focus like this" (YP)

The way in which young people viewed resettlement was hypothesised to have an effect on how successfully they integrated into Edinburgh communities and their goals for the future. The narrative from family members also impacted their feelings about taking the opportunities now available to them in Edinburgh.

Service 2 (16; 394-399) “If you’ve had trauma prenatally, postnatally, and developmentally all the way through, then that’s different to somebody who had positive early year experiences and their parents actually wanted to give them the best in life, and has sent them off to a different country to offer them a different opportunity” (S)

Saad (5; 149-151): “my family say stay in Scotland. This is your life there, this is good country good people good job because back in Syria is very bad for them” (YP)

Tied into this determination is a sense that young people should make the most of what’s been given to them by the host country. There was also a perceived need to give back to those less fortunate; Waseem in particular had been proactive in supporting other young people with R/AS.

Waseem (5; 164-166) “my English is better, so I’m doing volunteering now. I’m teaching {other refugee children} to speak English like reading and writing. I’ve been there for 8 months” (YP)

Literature regarding Identity

Social identity theory (Tajfel, 1978) suggests that individuals categorise themselves into groups based on perceived similarities and differences, such as age, gender or ethnicity. Upon resettlement, it may be that families with R/AS are classed by themselves and others as being different; an out-group. In turn, refugees have previously voiced concern about being treated negatively, at times leading to a strengthening in cultural beliefs or a rejection of their original beliefs in favour of those which allow them to belong within the majority group (Safak et al., 2020; Ozer, 2015). There were inconsistencies in the ways in which young people and mothers confronted issues with dual identity. There may have been division regarding ethnicity, adherence to religious beliefs and political stances. One such discussion revolved around drinking alcohol, something which is considered haram in Islam. This further emphasises the heterogeneity within the Syrian community, not to mention the wider refugee community as a whole. Additionally, age may have influenced the development of identity and sense of self (Arnold, 2017). Rebellion against parental beliefs and the formation of the teenagers own values and views is documented within the Western literature (Moreira, H., Gouveia, M. J., & Canavarro, 2018; Douglass & Umaña-Taylor, 2016), however caution must be taken when applying these models to other cultures.

As evidenced within this study, identity is not a static construct, it develops and changes over time with an individual's experiences of the world (Bauman, 2004; Timotijevic & Breakwell, 2000). The nature of someone's identity is perceived differently by themselves and by others, based on their awareness of the individual (Yau & Reich, 2019). The perception of a 'refugee' in Western cultures is generally of a vulnerable, desperate, help-seeking and traumatised individual (Tribe, 2019). Research with the R/AS community has tended to revolve around the narrative of trauma, thereby consolidating this view (Fazel et al., 2012; White, 2006). Without dismissing or undermining the very real experiences of trauma, the young people and mothers in this study displayed an overwhelming amount of resilience and strength. Similarly, Hopkins and Hill (2010) found that unaccompanied minors in Scotland embraced educational opportunities as a means to achieving future goals. The participants expressed an internal locus of control, displaying independence and taking responsibility for their own lives (Hopkins & Hill, 2010). Theories of resilience suggest that a strong sense of self, high emotional expression and positive early year experiences are associated with the development of adaptive behaviours (Brooks, 1994; Daud, af Klinteberg & Rydelius, 2008). Others highlight the importance of secure early attachment, access to a supportive family base, and a positive peer network (Garmezy, 1987; Bowlby, 1982; Mitra & Hodes, 2019). Similarly, theories of post-traumatic growth suggest that young people may experience positive change as a reaction to experiencing difficult experiences (Tedeschi & Calhoun, 2004). It can present as a greater appreciation for life and its opportunities, increased sense of personal strength, increased social connections and changes in values and goals (as evidenced in the young person narratives; Frankl, 1962; Bahar & Dooley, 2019). Again, despite attempts to research these theories in R/AS populations, it may be that Western frameworks of resilience may not fully capture the cultural differences and uniqueness of the circumstance (Bernal & Adames, 2017). By allowing individuals with R/AS to present their own accounts of their experiences, they can provide understanding how they have managed adversity and developed post-traumatic growth (Marlowe, 2010)

Unknown & Uncertainty

A sense of the unknown featured prominently throughout the service interviews and a perceived lack of guidance only exacerbated staff feelings of inadequacy and anxiety.

A real sense of the unknown

Several staff members reported the difficulty in engaging with traditional mental health work and the challenging of their expectations about young people and their needs.

Service 2 (1; 10-11) “There’s all the cultural differences and a real sense of the unknown. So people are trying to deal with what’s in front of them but don’t really know” (S)

Service 1 (8; 232-246) “I’ve found just really needing to step back and think about exactly what I was saying and what the words might directly translate to, so what is the direct translation for trauma, and it was something like {...} damaged, so it was trying to find the words to use {...} And using lots of visual aids as well, but even then trying to put in a picture what dissociation is quite tricky, especially when you’re doing that initial assessment so that was definitely a steep learning curve” (S)

Service 3 (11; 331-335) “My experience of CAMHS is that you may get a phone call and then you have to wait a long time so that would not work for families, due to already a mistrust of psychiatric services. I might not be representative but I don’t know of any young person who has received a service from CAMHS, any Syrian child. We have very little dealings with CAMHS, to me they’re a bit of a mystery, bit of a faceless organisation” (S)

A perceived lack of guidance led to uncertainty about how to progress with supporting young people and their families, with regards to living arrangements, cultural sensitivities and therapeutic engagement.

Service 2 (10; 253-254) “Having a sense the context and family and what’s happened to them really helps you to formulate an understanding of how they’ve got to where they are” (S)

Service 2 (21; 538- 542) “Although peoples’ expertise is increasing, there doesn’t feel like there’s been a strategic move, it still feels very ad hoc and it’s the ground level experience that has kinda changed things than actually making a strategic one. It may be that there is a strategic plan but I guess we’ve not heard” (S)

Lauren and Service 3 both expressed frustration at this lack of knowledge.

Lauren (5; 527-548) “At the point that Edinburgh took these kids on, they had no idea what they were doing and I don’t mean to be disrespectful but I do think the UK generally hadn’t done their homework about what they were taking on {...} there were bits they got like these kids will only eat halal so we’ll get halal in, and it was almost like, OK we’ve met their cultural needs and everything’s done. There were loads of bits that they just didn’t get about these kids, and there were times where they made life every difficult for themselves, they made rods for their own back by not actually trying to get more knowledge” (S)

Service 3 (8; 247-251) “I still think that more could have been done, and I know speaking to Scottish government, the response was too little too late (*sigh*) I have the impression that responses were being made up on the spot and there’s still no answers, so without being a sceptic, I think, that should have been thrashed out beforehand you know with people in government” (S)

It seems that the uncertainty over what services should be providing has led to an erosion of boundaries. Service 2 reported that the novelty of the arrival of R/AS families resulted in a lack of structured needs assessment, as experienced by Lauren. Worryingly, this may have put young people at risk of harm or further rejection.

Service 2 (11; 276-279) “there was an intrigue about these youngsters that came from exotic places and there was an informality that was allowed to happen and so people ended up allowed to become carers without the proper assessments” (S)

Lauren (2; 31-50) “he’d moved in and I think we’d met him just twice {...} It just happened so quickly. And then we had to go through some sort of process of approval to be carers but he was already well and truly feet under the table by that stage” (S)

Services shared some of their strategies to deal with the sense of unknown, and subsequent feelings of impotence and unease.

Service 1 (15; 540-544) “how do I find out about the culture, so that, generally in this culture, you would expect to be independent at this age. So who are our experts on that culture and obviously it’s the young people themselves who tell us about it, but it’s about finding out from somebody else whether that would be normal within their culture, not just the family.” (S)

Service 3 (14; 418-420) “Just made it very simple and made it kind of an informal group meeting. So strip away any kinda auspices of clinical feeling, I think that’s really important because the community will put up defences, the Syrian community is suspicious of psychiatric services” (S)

Service 2 (4; 90-97) “Making space for people who have had experiences to communicate together, to help them just manage those conversations and not assume that all kids will need the same response or to share ideas {...} It’s about facilitating those conversations, whether that’s consultations or through training.” (S)

That anxiety from the key worker

One of the key issues for services was comparing the expectation of R/AS families’ needs to what young people actually wanted support with.

Lauren (4; 96-100) “Having to learn our own preconceptions about Ethiopia and as a child through the 80s and Band-Aid and all the rest of it, was just all famine and starvation in Ethiopia and so that is your mindset. But of course he never experienced any of these things so you know having to completely rethink everything you think and know about Africa” (S)

A main concern for school and residential staff was the potential unknown impact of their traumatic experiences, whilst other services recognised the need for R/AS individuals to feel safe before attempting trauma reprocessing work.

Service 1 (11; 319-336) “That was the advice we gave to schools and Young Person’s Centres. Let people settle. We don’t need to come rushing in waving a magic wand and do the trauma work with them. Actually I get peoples anxiety, should we just refer them? they’ve a terrible history {...} And there’s a cultural assumption that is so awful, you must need to talk about it, but it’s potentially not the young person that needs to talk about it, it’s the people supporting them” (S)

Service 2 (13; 320-324) “there was a real feel from other agencies that we should start trauma work that we should be engaging them about their horrific experiences. And it took a lot of work to say to residential staff, you’re doing that work, to make them feel safe here, they’ve got all these symptoms but they’ve just arrived” (S)

Literature regarding Unknown & Uncertainty

As with R/AS families arriving to Edinburgh, the application of schema theories may be applied to the staff providing support. Within services, there are agreed upon ‘rules’ regarding the assessment and treatment of trauma reactions; which, when challenged, can cause anxiety in staff working with R/AS populations. The language and culture of mental health is derived from Western theories and vocabulary, and may not exist within other cultures (Tribe, 1999; Hinton & Lewis-Fernández, 2011). Even when young people are in an objectively safe environment, research shows that there is a clear distinction between being safe physically and feeling safe emotionally (Moore & McArthur, 2017). Having a trusted adult helps young people to feel safe, a necessity for allowing the processing of traumatic experiences (Herman, 1997). More generally, staff expectations that young people want to focus on their difficult memories may overshadow the more immediate needs of the young person, e.g. sleep, safety and dietary requirements (Fernando, 2010; Summerfield, 2005; Herman, 1997). The limited literature regarding R/AS mental health emphasises the necessity of gaining a general picture of the individual and their everyday lives, rather than a narrow focus on their traumatic experiences (Papadopoulos, 2001). Clinicians have acknowledged the adaptations to therapy to engage individuals; being more flexible, using a more directive approach or creating a more conversational, informal atmosphere (Century et al., 2007). However they reported limited guidance and a lack of consistency across services on how to best support R/AS young people.

Due to an ever-growing argument about generalising Western treatments to minority cultures without alternate approaches, staff can be left feeling helpless and powerless (Bogic, Njoku & Priebe, 2015; Robinson, 2013). Clinicians have used terminology such as, ‘overwhelmed, helpless, powerless, exhausted and isolated’ when describing the emotional impact of working with R/AS individuals (Century et al., 2007). The dominance of Western theories and frameworks, whilst understandable in UK services, can also serve to undermine the importance of alternative views and

the R/AS community's strengths and protective factors against emotional difficulties (Hughes, 2014). Cultural ignorance was described as a barrier to effective therapy and a concern about seeming naïve or inexperienced can prevent staff from asking for clarity regarding cultural norms (Century et al., 2007). Therapists have also reflected upon the difficulties of maintaining professional boundaries between themselves and their clients (West, 2004; Guhan et al., 2011). Approaches on how to manage this boundary erosion differed from clinician to clinician; either sticking more strictly to the boundaries or showing flexibility to allow for cultural sensitivities (Century et al., 2007). Robinson (2013) reported that many of the difficulties faced by staff could be mediated by the provision of consistent supervision, from an individual with culturally specific knowledge.

Vocational Discord

The theme of vocational discord refers to feelings of ambiguity between and within services supporting R/AS young people and families. Additionally, staff reported internal conflict regarding their role as clinician and their position within the legal system.

What's important here?

A common theme across staff groups was a sense of discord having been put in a difficult position regarding their own beliefs about the R/AS population and their professional responsibilities towards the legal system. It seemed that staff found it challenging to determine which agenda to prioritise.

Service 1 (5; 137-141) "I didn't want to scupper anything legal. I would do anything to just ease that awful process along to get those children settled so whatever was the sort of thing that was accepted was that's what I went along with. Even if someone who was working with the adults would come to me and say, you know Dads not actually Dad of those children. They're the carers in this position, they travelled miles with these children" (S)

Service 2 (18; 462-463) "because none of us have any knowledge about this, it's really scary, that actually if you sentence somebody to be an adult" (S)

Service 2 (10; 241-248) "a female carer wanted to give a young girl a sense that she can have a voice and that it was ok to argue with men and depending on where that young girl wants to see herself in the future, it's how she can hold both of those views {...} whether we agree with them or not doesn't really matter, they're both present. We not saying that our particular world view is the only view and how we're holding all the different views can be quite hard because we're all used to our set opinions aren't we?" (S)

Service 1 (18; 564-580) "an unaccompanied minor comes in here and they're put in a Young Person's Unit and they have a lot of rules and boundaries that are around a 14 year old, but they've just made their way across Europe and suddenly they're not allowed to be out beyond 9pm and

there is that kind of juxtaposition {...} and from their perspective it's like, come on! And the age {assessment} thing, if someone's been through that and they've worked since they were quite young and they've travelled independently, they probably do seem older because they've had that experience that someone at the age of 15 here would not have had." (S)

There was also a sense of discord between staff teams on how best to support young people and their families. Whilst this may have developed from staff anxiety, it led to inconsistencies and conflict between teams.

Service 2 (12; 305-309) "the unit staff had seemed to get a more realistic way of managing boundaries, and the teachers were very much in this idealised mind, they just need so much and you just have to love them so much. It was a very difficult meeting because of this vast polarisation of these two different approaches" (S)

Staff appeared open about some of the personal difficulties they had to address as part of working with R/AS families.

Service 1 (15; 444-446) "I remember being in the office when one of our colleagues came in {...} and she was in bits and when you read the story and how awful it was. And it felt traumatic hearing the story because you couldn't believe how awful that situation was." (S)

Service 3 (9; 262-264) "It has to be done within the context of long term goals as well and that needs to come from government, we're a small NGO down here. We don't have the capacity to set stuff up in terms of employment but personally I feel a sense of shame and embarrassment about the situation" (S)

Service 3 (15; 455-457) "I worry about their future, these kids. They're struggling with education, with integration, what does that mean in terms of their future? I mean, will they just grow up to be another generation of angry young men who have no sense of their worth or opportunities. Things need to change" (S)

Staff had suggestions about how they may be able to improve support including becoming more proactive with engaging the R/AS community, alternative therapies and being more flexible about time constraints.

Service 1 (17; 535-537) "There is a real willingness to have that learning curve but you know, time pressures, waiting list pressures, with all these things coming into play, there's not enough of us or other agencies, and I think we've had to make the best of what we've got." (S)

Service 3 (6; 156-164) "we've been reasonably proactive in terms of our involvement so that some of the barriers might not be the barriers that other agencies would be involved in, so maybe just trying to change how we offer services. For example transport may have been a barrier but then

so we've put transport on to ensure that the children can get to the services whereas if transport wasn't provided, I would say 50% of our kids wouldn't come" (S)

Service 1 (12; 275-280) "I do wonder whether the kind of talking therapies aren't as good but maybe doing something in a group where this is a way of connecting your life story in a way that you can't do with words. I'm just wondering whether maybe therapy needs to be more creative and provide different opportunities for different people, but also having the peer group that understands because they've been through something similar even if it's not exactly the same" (S)

Additional factors such as the lack of specialist services in Edinburgh were thought to affect staff's perceived ability to best support young people.

Service 2 (17; 430-433) "there is a concern that everything is in Glasgow in terms of Home Office and specialist resources so these youngsters find their lives going back and forward to Glasgow and I think that's a difficulty for all of them, how do they settle here because Glasgow is where all the power is" (S)

Service 2 (20; 503-507) "there is empirical evidence from lots of different bits of the country but there's something about this city and what we've got here and what has been learned here. {...} there's something very much about recognising the culture of this city" (S)

All services reported a desire for more linked working with other services, thus combining the expertise of mental health practitioners and those with experience working with R/AS families.

Service 1 (16; 500-514) "It would be great to do more joined up work with agencies that culturally are set up to work with them and some people that speak different languages, {...} I think we can miss only ever being able to talk to certain members of the family and have access to certain members of the family. Our hopes were I think it's fair to say, that our service would be more linked with adult services" (S)

Service 2 (21; 536-539) "A reflection would be that we are not probably as linked with {mental health} team as we should be, about thinking about these youngsters, and that's perhaps something that we need to own and kinda think about" (S)

Service 3 (12; 361-364) "what might be helpful might be if there were people available to act as consultants, so if you can't bring the service to the child, then you bring the service to the agency or the workers who can bring the service to the child and provide them with some support" (S)

Service 1 (10; 300-305) "It is a real shame because it means services can't change, {...} the more you hear the kind of system or service that we offer is probably not the best way of offering trauma work to this population. how can it be done differently using members of the culture that you skill up but I think without any one person sitting above housing education you know, there's no one kind of holding that and everyone just keeps going round doing our own little bits of it" (S)

Literature regarding Vocational Discord

Refugees may be understandably cautious of sharing their true stories for fear of disbelief, or the consequences on their asylum applications (Kohli, 2006; Maldonado et al., 2013). Staff groups empathised with the R/AS population about the necessity of this action however it also led to uncertainty about what staff could ask about a young person's experiences (Hacker, Chu, Arsenault & Marlin, 2012). Staff described being placed in a difficult position on whether to avoid discussing legal issues for fear of finding out information that they may be required to report to the Home Office. Service 2 reported the impact of 'sentencing' someone to adulthood, drawing comparisons with the criminal system (Lanza, 1983; Timmis, 2019). There appears to be extremely limited research exploring the experiences of staff managing the responsibilities of legal reporting (Kohli, 2006), however there were negative outcomes associated with similar conflicts of interest (Timmis, 2019; Miller & Weinstock, 1987; Muehleman & Kimmons, 1981). The impact of these dilemmas can include dismantling of trust between the R/AS population and public services. As described in *Connection & Disconnect*, the importance of rapport and trusting relationships cannot be ignored.

Staff reported that the novelty of the initial influx of R/AS families led to polarisation and inconsistency in staff approaches to R/AS care; one of the approaches has been to overwhelm children with support. Orientalism (Said, 1978) describes a process in which people from non-Western countries are conceptualised as 'exotic' and different. This can lead to a curiosity about young people with R/AS, and a reductionist perspective of their experiences. By placing refugees in an 'exotic vulnerable' role, the host country takes on the position of 'hero' and 'saviour' (Nayeri, 2019).

Staff reported a need for linked services to combine areas of expertise, to reduce the risk of projecting narratives, but also to provide specialist mental health interventions with the consideration of cultural sensitivities. The concept of individuality, an underlying principle in UK therapies is a Western construct whilst other cultures, often those from which R/AS populations originate, have a much greater focus on family and community, and a collectivist lifestyle (Liu et al., 2019). Staff recognised the importance of adapting therapy, however felt that knowledge was limited on how to best address the multiple complexities and discords when working with R/AS young people and families.

Reflective Account

Due to the nature of the project, keeping a reflective diary felt particularly relevant and highlighted the challenges and unanticipated rewards of working with an R/AS population. This project evoked, perhaps unsurprisingly, a number of difficult emotions based on the experiences of recruiting participants, and collecting and analysing the data. It should be noted that these reflections present personal experiences and interpretations.

Development of Project: As a volunteer with a charity working with women and children with R/AS, prior to the project, I could see a clear need for mental health support; children who hid under desks when aeroplanes flew over or who displayed emotion at seemingly insignificant scenarios. Families talked of nightmares and flashbacks and the isolation of living in a country where they didn't speak the language. Despite seeing the incredible work of charities, I had heard of a disproportionately low number of young people with R/AS accessing NHS mental health services. This research idea formed from the clear gap between the need for mental health support and the obvious lack of representation in public services.

Ethics: Due to cultural norms and the informality of interviews, it felt difficult to boundary my multiple roles within this project; researcher, trainee and volunteer. Despite trying to be clear about the boundaries of the research relationship, these often blurred regarding the expectations of participants for me to become involved in meals, helping with legal efforts and returning unrelated phone messages (all during interviews). Marlowe (2010) posits that research with such marginalised populations cannot, and should not be neutral or objective. Instead the researcher becomes politically and emotionally engaged, advocating for, and collaborating with those whose voices are often dismissed. As a clinician working with other vulnerable children, I felt a professional expectation to provide support and signpost to services. My position as a researcher was to outline the remit of my role within the context of these interviews. Advocacy occurred outside the interviews in the form of providing presentations regarding general mental health to charities and consulting with parents on the pathways to accessing mental health support for their children (Stevenson & Willott, 2006). It was also anticipated that the current study would provide implications for both public services and charities on how to best create meaningful change for families with R/AS.

Recruitment: From the beginning, it was anticipated that recruitment would be difficult, given the nature of the participant population. I frequently felt frustrated and confused at the lack of knowledge within NHS services about the R/AS community. Due to the lack of engagement with the R/AS community, there was an insufficient number of potential R/AS participants within NHS mental

health services. Unforeseen circumstances such as refusal for recruitment within social services, ethics amendment delays and the outbreak of COVID-19 added to my frustration over the lack of recruitment. Through my volunteering, it was relatively simple to advertise my research, as many of the families used multiple charities and the refugee community is very interconnected, as is the case with many ethnic minority populations (Blakemore, 2002). Information about the project travelled through word of mouth and many of the people I spoke to had already heard about my research, however, the step from interest to actual recruitment proved to be the most difficult part of the study. Throughout my project, my feelings of frustration changed, I often wondered about how the NHS teams could possibly be expected to identify and engage young people with R/AS with such limited resources, when I (with experience and connections within the refugee community) could not recruit potential participants.

One issue that commonly arises within refugee research is an insider-outsider dichotomy (Dwyer & Buckle, 2009). As a white female, brought up within the UK, there was a cognitive dissonance between (i) having no right to research refugees as a non-refugee and (ii) using my privilege as a member of the host community to provide an opportunity for meaningful change. There also appeared to be a need for commitment to the community, and reciprocity within the research context, with other researchers reporting the need to halt 'official research' to provide practical supports (Marlowe, 2010). Ultimately, the recruitment of participants with R/AS became an almost ethnographic approach (Riches & Dawson, 1996). For over two years, I have volunteered four or five times a week, outside of 'standard' recruitment strategies at various charities or NGO's across Lothian, teaching English to mothers, looking after young children in a playgroup, co-facilitating a wellbeing group for men with R/AS, attending protests and providing school tutoring for teenagers with R/AS. In hindsight, it feels like an enormous part of recruitment for this research was to gain the trust and acceptance of the refugee community and those supporting them. The existing R/AS literature base recognises these challenges (Rogers 2004; Trochim 2002; Stevenson & Willott, 2006), and advocate an intensive and informal approach of the researcher for recruitment. Although the aim of the study was to capture the experiences of young people and their families with R/AS, I found it invaluable to have an initial, albeit superficial, insight into social and cultural norms before continuing with recruitment. This is not to say that my involvement with the R/AS community was solely for recruitment; I have enjoyed volunteering and learning about a different culture and religion, and I have multiple connections within the community, who I may never have met without pushing the boundaries of 'traditional' recruitment strategies. At the beginning of recruitment, I also found it difficult to understand why charities may be reluctant or wary to provide the details of potential participants, however this protective stance became clearer as I learned more about what

communities had been through and the ignorance and hostility towards people with R/AS (Sukarieh & Tannock, 2013; Lugo, 2007).

Data Collection: It was anticipated that issues around language, culture and social norms, as well as my role as a person from the host country, would have an impact on the information shared by participants (Stevenson & Willott, 2006). A key challenge to the collection of detailed data was the language barrier, inciting the need for simpler English, adapted questions and the involvement of interpreters in both obtaining consent but also for interviews. Practically, it was a challenge organising interpreters through the NHS or public services, and I felt myself mirroring the frustration of many R/AS families when interpreters did not turn up to appointments.

Through my volunteering, I heard of Home Office interview processes which inadvertently taught ‘buzzwords’ needed to be granted asylum, indicating the need for the right or desired story, rather than the true experience of the young person. As an ‘outsider’ to the R/AS community, I anticipated that this might affect the way in which participants may report their experiences to me, e.g. not discussing the negative experiences of Scotland for fear of retribution. As my questions were aimed at identifying difficulties with the resettlement process and access to services, this is something I was mindful of and may have impacted my later interpretation of silences, back-tracking or contradictory statements (Puvimanasinghe, Denson, Augoustinos & Somasundaram, 2015).

Being given the opportunity to try and understand the experiences of families with R/AS led to me feeling humbled by the resilience and strength of my participants, and instigated a real need for this project to produce real change for these families. Certainly, I believe my close involvement with the community increased the emotional impact of hearing the experiences of my participants, but also provided me with an opportunity to ask difficult questions not always afforded to those outside the community. Despite my aforementioned concerns, their openness to share some of the most difficult experiences with me and show emotion despite the cultural stigma surrounding mental health was overwhelming, especially as many of their experiences were unfathomable. The participants talked far beyond the guiding themes of the interview, despite careful considerations around asking about journeys and traumatic memories. I felt privileged that both R/AS and staff participant groups shared their frustrations, fears, ambitions and hopes for the future, despite my close role as colleague or acquaintance to many of the participants. It emerged that many of the participants had not been asked to share their stories outside of Home Office interviews, and often they felt it was good to talk about difficulties without fear of consequence.

Waseem (7, 228-229) “I don’t want to tell anyone before but you want to talk about these things. It’s nice to say” (YP)

Data Analysis: The reflections and experiences of recruitment and data collection, unsurprisingly, had an impact on how I approached data analysis. Due to the huge amounts of information gathered in the study, I found it difficult to narrow analysis into interpretable themes; feeling dismissive of participants' experiences if I chose to prioritise certain themes over others. During analysis, I once more felt the frustration and helplessness of young people, family members and charity workers at the decisions of policy-makers, the Home Office and public services. As a trainee, I had the perspective of NHS staff teams, attempting to provide support with a distinct lack of resources, knowledge or connections with the community. Throughout my research, all the staff I met expressed a desire to learn, engage and support each other in a process in which there are no clear mental health guidelines. This led to me to feel critical of policy-makers and funders, where all participant groups identified clear gaps in care.

Many young people had never heard of the term 'mental health' and I was very aware of the biases that I may bring to the interpretation, based on my demographics and education in Western frameworks of mental health. Additionally, as a psychology trainee, it was natural for me to look for difficulties faced by all participant groups, perhaps limiting the focus of interviews to majority negative experiences. Attempts to be open to new understandings and information about adapting to difficult circumstances were discussed in supervision.

Finally, I believe that the research process has had an impact on my clinical work. Rather than using open-ended questions, I noticed myself providing several choices to participants, perhaps limiting their answers and missing out on valuable insights. This is especially important in a culturally diverse population who may view things differently to me. I have consequently adapted my approach within clinical sessions to provide fuller opportunities for sessions to be client-led. As a trainee, there is often anxiety about appearing ignorant or inadequate. I believe that after R/AS interviews, I felt more willing to ask questions about cultural norms, and acknowledge when I didn't have all the answers. This again has filtered into my clinical work, and I believe has increased my confidence in allowing service-users to be the experts of their mental health care.

Discussion

This study aimed to explore the experiences of young refugees, their families and involved organisations within the process of resettlement. There is increasing research recognising the importance of first-hand information from those directly affected. Using IPA, this study identified four themes across all three participant groups (*Trust & Safety*, *Connection & Disconnect*, *Meeting Needs* and *Identity*), one theme specific to R/AS families (*Loss & Longing*) and two themes specific to the service participant group (*Unknown & Uncertainty* and *Vocational Discord*).

Key findings from each theme are described in Table 2. Due to the vast amount of data collected, these key findings emerge from considering the research aims, but also the implications these findings could have on further research and clinical service change.

Table 2: Summary of Key Findings

Theme	Key Findings
Trust & Safety	<ul style="list-style-type: none"> • R/AS participants contextualised their current situation by sharing pre-migration memories of violence and trauma. • Concern for loved ones left behind featured heavily throughout the interviews. The sense of fear and helplessness at not knowing about relatives' well-being often left participants in tears. • Feelings of distrust derived from the punitiveness of the asylum-seeking process led to uncertainty on both sides on how to proceed with building relationships.
Connection & Disconnect	<ul style="list-style-type: none"> • Participants described clear stages of adjustment including an initial several months isolated within their homes, learning English and building relationships. • Barriers to integration included multiple moves, racism, ongoing language difficulties, leading to feelings of disconnect from the Edinburgh community. • Services felt the need to be increasingly proactive and communicate differently than with local young people. • Services expressed concern for workers who may have personal connections with the R/AS community and a lack of support from a professional capacity.
Loss & Longing	<ul style="list-style-type: none"> • Both R/AS participant groups had experienced extreme loss in relation to their families, friends, material possessions and future opportunities. • A sense of longing for these losses led to attempts at reconnecting with familiar foods, cultural groups and emotional states (care-free childhood). • Service attempts to support these reconnections included the use of food and reciprocal sharing of cultural beliefs. Other services felt that their system structure limited their ability to support these activities.
Meeting Needs	<ul style="list-style-type: none"> • R/AS participants spoke of the gratitude toward the Edinburgh community, however it was also hypothesised that participants may have felt obligated to express gratefulness. • With regards to unmet needs, R/AS participants felt that they were alone in taking responsibility for their own difficulties. Conversely, participants asked for support with a variety of unmet needs and suggested methods of improvement in resettlement care. • Although participants identified practical needs only, it was theorised that these difficulties had a large influence on their psychological wellbeing.

Identity	<ul style="list-style-type: none"> •Participants expressed strong feelings of national identity, but inconsistency about their connections with journey countries. •Many young people reported positive emotions regarding their Scottish identity. It helped them to build relationships and 'fit' into their peer groups. •Normal teenage developmental changes to identity were complicated by participant's experiences of loss and their educational attainment. •Narratives projected onto young people by the Home Office process and Edinburgh's understanding refugee status could negatively affect identity and sense of self. •Theories of resilience and post-traumatic growth were used to understand the emotional strength and sense of determination perceived in these R/AS participants.
Unknown & Uncertainty	<ul style="list-style-type: none"> •Services reported a sense of unknown about how to best engage and support the R/AS population in Edinburgh, including issues of culture, staff responsibilities and types of care. •There was a perceived lack of guidance for staff leading to feelings of uncertainty, unease and avoidance. •Traditional professional boundaries felt difficult to maintain and in some cases, led to the breakdown of foster placements and relationships with services.
Vocational Discord	<ul style="list-style-type: none"> •Staff reported personal challenges when supporting R/AS families, including secondary trauma, lack of support and being placed in a difficult position regarding their legal responsibilities. •There was a vast polarisation in team approaches, leading to conflicts within services and inconsistent support for young people. •Services reported wondering 'What's most important here?' leading to a prioritisation of several elements of care. Unfortunately staff felt that this process was also complicated by cultural and language differences. •There was a desire from all services for increased consultation and linking of services, to combine areas of expertise.

Studies using IPA acknowledge the idiosyncrasy of lived experiences and usually do not make claims of external validity or generalisability (Smith et al., 1999). Instead, the findings may be considered theoretically generalizable, rather than statistically or empirically generalizable (Green, 1999). Although the experiences of each participant are unique, common themes included insecurity, loss, and difficulty adjusting to Edinburgh culture. These findings are similar to that of other R/AS studies (Goodman, 2004; Miller et al., 2002; Strijk, van Meijel & Gamel, 2010; Gorst-Unsworth & Goldenberg, 1998; Kovacev & Shute, 2004; Berthold, 2000; Carswell et al., 2011; Lie, 2002; Luster et al., 2008).

Individuals with R/AS reported being torn between two worlds, pre-migration and post-settlement lives. Similar to some models of integration, the findings of this study promote a holistic approach to R/AS resettlement in Edinburgh (Silove, 2000; Ager & Strang, 2008; Phillimore, 2012). Initial expectations of local communities were challenged as they learnt more about the acute needs of R/AS individuals (Maslow 1948). Theories must consider the process of resettlement within the

context of traumatic experiences, but also listen to young people, families and staff working with them about what their true needs may be. Theories of grief appeared to partially fit with the experiences of R/AS participants, however there were complexities that were not often addressed in traditional frameworks, e.g. cultural sensitivities or uncertainty of their loved one's wellbeing (Kubler-Ross, 1969; Hamilton, 2016). Furthermore, adjustment, resilience and post-traumatic growth frameworks were also somewhat applicable to the narratives in this study (Janoff-Bulman, 1992; Newsome & Kendall, 1996; Tedeschi & Calhoun, 2004). In order to fully understand and support emotional wellbeing and mediate everyday stressors, clinicians must consider the traditional coping strategies of R/AS individuals and respect cultural differences.

The New Scots Strategy (2018-2022) was evaluated against the findings of this study. Whilst consideration had been given to issues from the previous policy (New Scots Strategy, 2014), services still voiced concern and uncertainty about how best to implement changes. The five principles which characterise the New Scots approach are outlined in Table 3.

Table 3: Principles of the New Scots Strategy (2018-2022)

Principles	Expectations	Study Findings
Integration From Day One	R/AS families should be supported to integrate from arrival and not wait until asylum has been granted	<ul style="list-style-type: none"> •Support workers helped families with appointments, financial and medical requirements amongst other roles. •Families reported spending several months isolated in their homes. •Services were willing to engage but felt that there was little guidance on how to manage initial communication
A Rights Based Approach	Empower people to understand and exercise their rights. People should be supported because it is morally right that people should feel safe and have a sense of belonging	<ul style="list-style-type: none"> •R/AS participants reported a lack of knowledge about the asylum process and how to access legal support •Participants seemed compelled to express gratefulness to the Scottish government, rather than feeling that they had the right to be resettled
Refugee Involvement	Actively encourage R/AS individuals to be involved in developing and shaping the strategy	<ul style="list-style-type: none"> •This was not explicitly discussed, however participants did report several common suggestions for improvement that they felt would help support their well-being and further integration. This implies that their views and values were potentially not as involved as they could be. •Services also felt that the policy was not supported by on-the-ground funding, resource or knowledge to implement suggested strategies

Inclusive Communities	Both R/AS and local individuals to be involved in building connections between communities	<ul style="list-style-type: none"> •Both R/AS and service participant groups felt disconnected from each other due to a number of barriers including language and racism. •R/AS participants reported some efforts at engaging with neighbours but felt that some efforts had been dismissed. •Services reported that they were uneasy and felt worried about engaging R/AS individuals for fear of offence regarding cultural norms
Partnership and Collaboration	Coordinate the efforts of public services and charities to collaborate in supporting R/AS resettlement	<ul style="list-style-type: none"> •All services reported feelings of disconnect from each other •NGO's described public services as 'faceless' whilst public services felt ill-equipped to identify and communicate with specialist R/AS services.

Study Strengths

Despite the acknowledged complexities of refugee resettlement, many policies are based solely on third-party accounts of R/AS families' difficulties. The host community's expectations and perceptions of refugees and asylum seekers are influenced by the media, cultural and language barriers and stories of extreme violence and desperation (Nayeri, 2019). This can lead to distorted understanding of R/AS experiences and needs, especially regarding trauma and vulnerability (Marlowe, 2010; Ensign, 2003). This study allowed the opportunity for key stakeholders in the resettlement process to voice their own experiences and provide accurate and meaningful information for guidance and policy development (Esses, Medianu & Lawson, 2013; Thommessen et al., 2015).

To the researcher's knowledge, this study is one of a very limited number of studies who have used IPA by triangulation of multiple perspectives, and is unique in using this method for the exploration of R/AS resettlement (Mirdal et al., 2012; Mjøsund et al., 2017; Larkin et al., 2019). As the process of resettlement is complex and systemic, it requires a holistic framework to address the issues which affect all involved, rather than considering each voice in isolation from each other. By using a polyvocal approach, this research was able to capture several of the main voices which may impact a child's narrative (Gaywood et al., 2020).

Study Limitations

Due to the difficulty of engaging refugee populations, this study relied partly on a snowballing technique for recruitment, therefore participants generally shared similar social circles and ethnicities. All participants in this study arrived in Edinburgh as part of the VPR Scheme, providing them with a unique experience of arrival into the United Kingdom. Families were generally able to

stay together, given financial and housing support and guaranteed refugee status. As a result, their experiences of resettlement may be very different from those of a young person who arrived illegally, as an unaccompanied minor or seeking asylum upon arrival. An insight into one such experience was given through the narrative of Lauren (carer) however the findings of this study must be interpreted with caution. Previous research has fallen into the trap of over-generalising the experiences of ethnic minorities and refugees, despite a high level of heterogeneity within the R/AS population (Larruina & Ghorashi, 2020). Although this study provides a rich insight into the lived experiences of the participants, it is important to acknowledge limitations in the fair subject selection, as outlined in Ethics (Ellis et al., 2007).

Despite the inclusion of young people aged 10-18, participants were aged 15 and older, due to practical difficulties with obtaining parental consent for younger participants. Study findings are therefore limited to the experiences of older teenagers. Additionally, the researcher attempted to recruit R/AS fathers, as this group's voice are marginalised even within in R/AS research and more generally within family research (Cassano, Adrian, Veits, & Zeman, 2006). Service 3 suggested that resettlement for R/AS men has particular connotations for families, including employment, mental health and identity issues. Unfortunately due to COVID-19 restrictions, the fathers' focus group was cancelled and therefore this study was not able to gain first-hand information on their experiences.

The researcher was clear that language would not be a barrier to participation and therefore interpreters were provided. Only one young person used an interpreter, but there were clear examples of other young people misunderstanding questions or not having the right language to express themselves. Furthermore, many young person participants reported difficulties remembering details of pre-migration life, their journey and parts of their resettlement. It may be that these factors limited the accuracy and richness of information gathered during interviews.

Finally, as with all qualitative research, the biases of the researcher will have an impact on the analysis and themes that emerge from the data (Smith et al., 2015). A reflective diary was employed to address these issues and additional feedback from participants on themes was integrated into the analysis, however potential biases must still be acknowledged.

Research Implications

It can be difficult to access certain types of information using a quantitative methodology within the R/AS population, due to the uniqueness of their experiences. Future studies may be able to further contribute to the research base by exploring the broader context of resettlement stressors, rather than using questionnaires which pre-select factors to measure.

Although there are many theories applicable to the experiences of R/AS families, these are usually based upon Western frameworks. They may not capture the cultural complexities of R/AS resilience, especially in the context of pre-migration, journey and post-settlement experiences. This can also cause difficulties for host community services in understanding their service-users. Areas of interest for further research could include

- Exploration of the unique resilience factors and coping strategies of R/AS young people and families.
- Exploration of how different components of the resettlement process may have different levels of impact on emotional well-being
- Inclusion of fathers and children (<15 years old) in R/AS research and their impact on family dynamics
- Longitudinal research following families from initial arrival for several years to determine how needs and integration change over time
- Pilot studies evaluating service alterations (see Clinical Implications)
- Further exploration into the experiences of staff in mainstream clinical services, with emphasis on conflicting responsibilities and personal challenges
- Services reported having made informal alterations to their care. Future research could formally recognise and evaluate these adaptations

Clinical Recommendations

Implications for service development include greater access to high quality care from mental health and social care services, therefore preventing further long-term involvement of services. The Western distinctions made between mental health, physical health and social care needs can be unhelpful for R/AS populations. As identified, there were a number of factors across these three domains which connected and influenced each other, e.g. trauma presentations exacerbated by concerns regarding housing or financial security. The placement of mental health difficulties as within the R/AS individual's control can lead to feelings of blame and disempowerment. Additionally, families and young people are unlikely to be receptive to psychotherapy, when there are more immediate concerns of physical needs e.g. food (Watters, 2001; Maslow, 1947). The findings of this

study may allow professionals to consider the socio-political contexts involved in mental health, advocate for close working relationships between professional services and promote community and societal change. Clinically, an ideal treatment modality may be initially focused on a hierarchy of needs (Maslow, 1945), where R/AS families attend community-based hubs. More basic needs, such as those outlined in this study may need to be prioritised, whilst mental health can be further addressed when families feel safe and contained within the community hub (Watters, 2001; Bahar & Dooley, 2019). As voiced by Service 2, the unique culture and resource of Edinburgh must also be considered. The list below describes the participant's suggestions for improved integration.

- Increased information and guidance around the asylum process. This can also include providing emotional support throughout the Home Office process, and when discussing reunification difficulties
- Normalisation and containment of anxiety and grief about losses
- Increased social activities for young people and/or families to visit local tourist sites and learn about Scottish culture
- Increased language support in schools to support young people to learn
- Increased emotional support for young people, in an educational context
- Buddy systems for each family member to build relationships and create a social network within the Edinburgh community
- Reciprocal volunteering opportunities, e.g. helping the newly arrived to learn English
- Increased information about the local area e.g. doctor, supermarket, leisure centres, charities etc.
- Support for mothers including childcare, employment, self-confidence, peer support
- Support for fathers including peer relationships, employment, self-confidence, language
- Improved and consistent interpreter service for the benefit of both R/AS families and staff
- Appropriate training for staff and volunteers, including schools e.g. cultural norms, mental health, self-care, legal responsibilities
- Increased and consistent supervision and emotional support for interpreters, volunteers, support workers etc.
- 'Bottom-up' policy decisions for staff and services; guidance based on research conducted in naturalistic settings
- Increased links with other services; meetings for multiple services to share their experiences and provide support and consultation for each other
- Signposting for families with R/AS, services and carers to provide information about cultural groups, religious groups, minority supermarkets etc.

- Proactive engagement of young people and families with R/AS by providing transport options, working within schools and local communities

Further to participant suggestions, the researcher identified additional recommendations. In particular, mother participants spoke of the impact of financial and housing difficulties. It is well documented that the inconsistency of quality of housing and multiple moves can impact on mental health (Silove & Ekblad, 2002). Both R/AS groups described difficulties with communication and building friendships, further exacerbated by the temporariness of their living arrangements. Public inquiries into 'duty-of-care failures' have repeatedly recommended increased communication between services involved in an individual's care (APPG, 2017) and increased accountability of private providers, e.g. Serco or Mears Group (Scottish Refugee Council, 2020). Overlapping professional boundaries and increased links between healthcare, social services and housing could increase access to appropriate support and inform professionals of extenuating circumstances, e.g. transport difficulties, mental health presentations, the need for social connection with other R/AS families etc. (APPG, 2017, Ager & Strang, 2008). In line with Summerfield (1999), the need for safe and permanent housing was a frequent request from both R/AS mothers and young people. R/AS families could benefit from a psychologically-minded approach to housing applications and ongoing accommodation;

- Permanent housing upon arrival, with appropriate facilities and space for the family
- Relocation of families kept to a minimum, and if possible, relocation should be within the local area where social connections have already developed (unless otherwise requested)
- Training for housing staff on the potential implications of multiple moves with short notice
- Direct communication with housing staff (and interpreter) available 24hours a day in the event of emergency or queries

Although systemic changes can be resource-consuming in the short term, it is hoped that the long-term effects will be far-reaching and preventative of further difficulties with housing and other services (Fazel et al., 2012).

Due to the stigma associated with mental health in some cultures, services have recognised initial barriers to accessing support and that, once engaged, traditional talking therapies may not be appropriate. A move away from medical and clinical models may help to initially build engagement with young people and families with R/AS. Considering the importance of social bonds and collectivism within many refugee cultures, services could provide opportunities for group work and potentially develop mentoring schemes for young people to be supported by peers who may be of a similar culture. Suggestions of alternative support include youth groups, sports, music or art therapy

and opportunities to share culture between the R/AS and host communities. It is anticipated that this may encourage families to retain and celebrate their unique differences, building on self-esteem and identity. This may also allow Edinburgh locals to understand and develop relationships with R/AS families.

Finally, this study recognises the overwhelming resilience and strength displayed by all R/AS participants, and their determination to make the most of every opportunity, despite extremely difficult backgrounds. Instead of forcing Western theories and coping strategies, services could recognise the strategies used by R/AS individuals that allow them to function day to day. Strength-based and problem solving approaches may work well within this context, (see Systematic Review).

Conclusions

Scottish legislation states that, it is the right of every child to feel safe and have the opportunities to reach their full potential. It is hoped that the findings and dissemination of this research will be far-reaching. This study was able to promote safe conversations about mental health within families, reduce the stigma of mental health difficulties and increase the knowledge of available support for young refugees and their families. It is anticipated that empowering young refugees and their families to voice their experiences will allow further engagement and decision-making within Edinburgh teams and enhance integration within their new communities.

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Appendices

Appendix A: Guidelines for Journal of Child and Adolescent Mental Health

- An initiative started by *CrossRef* to help its members actively engage in efforts to prevent scholarly and professional plagiarism. The journal to which you are submitting your manuscript employs a plagiarism detection system. By submitting your manuscripts to this journal you accept that your manuscript may be screened for plagiarism against previously published works.
- Manuscripts should be double spaced and conform to the house style of *CAMH*. The title page of the manuscript should include the title, name(s) and address(es) of author(s), an abbreviated title (running head) of up to 80 characters, a correspondence address for the paper, and any ethical information relevant to the study (name of the authority, data and reference number for approval) or a statement explaining why their study did not require ethical approval.

•*Summary:* Authors should include a structured Abstract not exceeding 250 words under the sub-headings: Background; Method; Results; Conclusions.

•*Key Practitioner Message:* Below the Abstract, please provide 1-2 bullet points answering each of the following questions:

- **What is known?** - What is the relevant background knowledge base to your study? This may also include areas of uncertainty or ignorance.
- **What is new?** - What does your study tell us that we didn't already know or is novel regarding its design?
- **What is significant for clinical practice?** - Based on your findings, what should practitioners do differently or, if your study is of a preliminary nature, why should more research be devoted to this particular study?

•Papers submitted should be concise and written in English in a readily understandable style, avoiding sexist and racist language. Articles should adhere to journal guidelines and include a word count of their paper; occasionally, longer article may be accepted after negotiation with the Editors.

•Headings: Original articles should be set out in the conventional format: Methods, Results, Discussion and Conclusion. Descriptions of techniques and methods should only be given in detail when they are unfamiliar. There should be no more than three (clearly marked) levels of subheadings used in the text.

•All manuscripts should have an Acknowledgement section at the end of the main text, before the References. This should include statements on the following:

•*Study funding:* Please provide information on any external or grant funding of the work (or for any of the authors); where there is no external funding, please state this explicitly.

•*Contributorships:* Please state any elements of authorship for which particular authors are responsible, where contributorships differ between author groups. (All authors must share responsibility for the final version of the work submitted and published; if the study include original data, at least one author must confirm that he or she had full access to all the data in the study and takes responsibility for the integrity of the data in the study and the accuracy of the data analysis).

•*Conflicts of interest:* Please disclose any conflicts of interest of potential relevance to the work reported for each of the authors. If no conflicts of interest exist, please include an explicit declaration of the form: "The author(s) have declared that they have no competing or potential conflicts of interest".

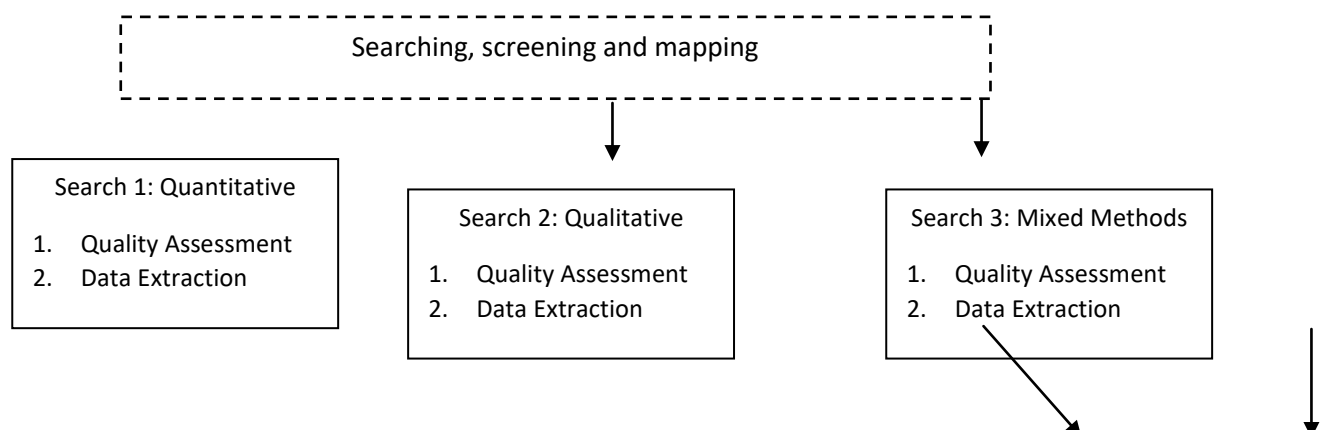
•For referencing, *CAMH* follows a slightly adapted version of APA Style. References in running text should be quoted showing author(s) and date. For up to three authors, all surnames should be given on first citation; for subsequent citations or where there are more than three authors, 'et al.' should be used. A full reference list should be given at the end of the article, in alphabetical order.

- References to journal articles should include the authors' surnames and initials, the year of publication, the full title of the paper, the full name of the journal, the volume number, and inclusive page numbers. References to chapters in books should include authors' surnames and initials, year of publication, full chapter title, editors' initials and surnames, full book title, page numbers, place of publication and publisher.
- Tables: These should be kept to a minimum and not duplicate what is in the text; they should be clearly set out and numbered and should appear at the end of the main text, with their intended position clearly indicated in the manuscript.
- Figures: Any figures, charts or diagrams should be originated in a drawing package and saved within the Word file or as an EPS or TIFF file. Titles or captions should be clear and easy to read.
- Footnotes should be avoided, but end notes may be used on a limited basis.
- Full guidance on Supporting Information including file types, size and format is available on the Wiley Author Service website.

Review Articles

- Research Articles offer our readers a critical perspective on a key body of current research relevant to child and adolescent mental health and maintain high standards of scientific practice by conforming to systematic guidelines as set out in the PRISMA statement. These articles should aim to inform readers of any important or controversial issues/findings, as well as the relevant conceptual and theoretical models, and provide them with sufficient information to evaluate the principal arguments involved. All review articles should also make clear the relevancy of the research covered, and any findings, for clinical practice.
- Your Review Article should be no more than 8,000 words excluding tables, figures and references and no more than 10,000 including tables, figures and references.

Appendix B: Process for Mixed Methods Systematic Review, adapted from Harden (2010).



All studies included and systematically assessed

Appendix C: Quality Criteria for Studies (Kmet, Cook & Lee, 2004)

Quality Scoring of Quantitative Studies

How to calculate the summary score

- Total sum = (number of “yes” * 2) + (number of “partials” * 1)
- Total possible sum = 28 – (number of “N/A” * 2)
- Summary score: total sum / total possible sum

Quality assessment

1. Question or objective sufficiently described?

- Yes: Is easily identified in the introductory section (or first paragraph of methods section). Specifies (where applicable, depending on study design) all of the following: purpose, subjects/target population, and the specific intervention(s)/association(s)/descriptive parameter(s) under investigation. A study purpose that only becomes apparent after studying other parts of the paper is not considered sufficiently described.
- Partial: Vaguely/incompletely reported (e.g. “describe the effect of” or “examine the role of” or “assess opinion on many issues” or “explore the general attitudes”...); or some information has to be gathered from parts of the paper other than the introduction/background/objective section.
- No: Question or objective is not reported, or is incomprehensible.
- N/A: Should not be checked for this question.

2. Design evident and appropriate to answer study question? (*If the study question is not given, infer from the conclusions*).

- Yes: Design is easily identified and is appropriate to address the study question /objective.
- Partial: Design and /or study question not clearly identified, but gross inappropriateness is not evident; or design is easily identified but only partially addresses the study question.
- No: Design used does not answer study question (e.g., a comparison group is required to answer the study question, but none was used); or design cannot be identified.
- N/A: Should not be checked for this question.

3. Method of subject selection (and comparison group selection, if applicable) or source of information/input variables (e.g., for decision analysis) is described and appropriate.

- Yes: Described and appropriate. Selection strategy designed (i.e., consider sampling frame and strategy) to obtain an unbiased sample of the relevant target population or the entire target population of interest (e.g., consecutive patients for clinical trials, population-based random sample for case-control studies or surveys). Where applicable, inclusion/exclusion criteria are described and defined (e.g., “cancer” -- ICD code or equivalent should be provided). Studies of volunteers: methods and setting of recruitment reported. Surveys: sampling frame/ strategy clearly described and appropriate.
- Partial: Selection methods (and inclusion/exclusion criteria, where applicable) are not completely described, but no obvious inappropriateness. Or selection strategy is not ideal (i.e., likely introduced bias) but did not likely seriously distort the results (e.g., telephone survey sampled from listed phone numbers only; hospital based case-control study identified all cases admitted during the study period, but recruited controls admitted during the day/evening only).

Any study describing participants only as “volunteers” or “healthy volunteers”. Surveys: target population mentioned but sampling strategy unclear.

- No: No information provided. Or obviously inappropriate selection procedures (e.g., inappropriate comparison group if intervention in women is compared to intervention in men). Or presence of selection bias which likely seriously distorted the results (e.g., obvious selection on “exposure” in a case-control study).
- N/A: Descriptive case series/reports.

4. Subject (and comparison group, if applicable) characteristics or input variables/information (e.g., for decision analyses) sufficiently described?

- Yes: Sufficient relevant baseline/demographic information clearly characterizing the participants is provided (or reference to previously published baseline data is provided). Where applicable, reproducible criteria used to describe/categorize the participants are clearly defined (e.g., ever-smokers, depression scores, systolic blood pressure > 140). If “healthy volunteers” are used, age and sex must be reported (at minimum). Decision analyses: baseline estimates for input variables are clearly specified.
- Partial: Poorly defined criteria (e.g. “hypertension”, “healthy volunteers”, “smoking”). Or incomplete relevant baseline / demographic information (e.g., information on likely confounders not reported). Decision analyses: incomplete reporting of baseline estimates for input variables.
- No: No baseline / demographic information provided. Decision analyses: baseline estimates of input variables not given.
- N/A: Should not be checked for this question.

5. If random allocation to treatment group was possible, is it described?

- Yes: True randomization done - requires a description of the method used (e.g., use of random numbers).
- Partial: Randomization mentioned, but method is not (i.e. it may have been possible that randomization was not true).
- No: Random allocation not mentioned although it would have been feasible and appropriate (and was possibly done).
- N/A: Observational analytic studies. Uncontrolled experimental studies. Surveys. Descriptive case series / reports. Decision analyses.

6. If interventional and blinding of investigators to intervention was possible, is it reported?

- Yes: Blinding reported.
- Partial: Blinding reported but it is not clear who was blinded.
- No: Blinding would have been possible (and was possibly done) but is not reported.
- N/A: Observational analytic studies. Uncontrolled experimental studies. Surveys. Descriptive case series / reports. Decision analyses.

7. If interventional and blinding of subjects to intervention was possible, is it reported?

- Yes: Blinding reported.
- Partial: Blinding reported but it is not clear who was blinded.
- No: Blinding would have been possible (and was possibly done) but is not reported.
- N/A: Observational studies. Uncontrolled experimental studies. Surveys. Descriptive case series / reports.

8. Outcome and (if applicable) exposure measure(s) well defined and robust to measurement / misclassification bias? Means of assessment reported?

- Yes: Defined (or reference to complete definitions is provided) and measured according to reproducible, “objective” criteria (e.g., death, test completion— yes/no, clinical scores). Little or minimal potential for measurement /misclassification errors. Surveys: clear description (or reference to clear description) of questionnaire/interview content and response options. Decision analyses: sources of uncertainty are defined for all input variables.
- Partial: Definition of measures leaves room for subjectivity, or not sure (i.e., not reported in detail, but probably acceptable). Or precise definition(s) are missing, but no evidence or problems in the paper that would lead one to assume major problems. Or instrument/mode of assessment(s) not reported. Or misclassification errors may have occurred, but they did not likely seriously distort the results (e.g., slight difficulty with recall of long-ago events; exposure is measured only at baseline in a long cohort study). Surveys: description of questionnaire/interview content incomplete; response options unclear. Decision analyses: sources of uncertainty are defined only for some input variables.
- No: Measures not defined, or are inconsistent throughout the paper. Or measures employ only ill-defined, subjective assessments, e.g. “anxiety” or “pain.” Or obvious misclassification errors/measurement bias likely seriously distorted the results (e.g., a prospective cohort relies on self-reported outcomes among the “unexposed” but requires clinical assessment of the

“exposed”). Surveys: no description of questionnaire/interview content or response options.

Decision analyses: sources of uncertainty are not defined for input variables.

- N/A: Descriptive case series / reports.

9. Sample size appropriate?

- Yes: Seems reasonable with respect to the outcome under study and the study design. When statistically significant results are achieved for major outcomes, appropriate sample size can usually be assumed, unless large standard errors ($SE > 1/2$ effect size) and/or problems with multiple testing are evident. Decision analyses: size of modelled cohort / number of iterations specified and justified.
- Partial: Insufficient data to assess sample size (e.g., sample seems “small” and there is no mention of power/sample size/effect size of interest and/or variance estimates aren’t provided). Or some statistically significant results with standard errors $> 1/2$ effect size (i.e., imprecise results). Or some statistically significant results in the absence of variance estimates. Decision analyses: incomplete description or justification of size of modelled cohort / number of iterations.
- No: Obviously inadequate (e.g., statistically non-significant results and standard errors $> 1/2$ effect size; or standard deviations $> _$ of effect size; or statistically non-significant results with no variance estimates and obviously inadequate sample size). Decision analyses: size of modelled cohort / number of iterations not specified.
- N/A: Most surveys (except surveys comparing responses between groups or change over time). Descriptive case series / reports.

10. Analysis described and appropriate?

- Yes: Analytic methods are described (e.g. “chi square” / “t-tests” / “Kaplan-Meier with log rank tests”, etc.) and appropriate.
- Partial: Analytic methods are not reported and have to be guessed at, but are probably appropriate. Or minor flaws or some tests appropriate, some not (e.g., parametric tests used, but unsure whether appropriate; control group exists but is not used for statistical analysis). Or multiple testing problems not addressed.
- No: Analysis methods not described and cannot be determined. Or obviously inappropriate analysis methods (e.g., chi-square tests for continuous data, SE given where normality is highly unlikely, etc.). Or a study with a descriptive goal/ objective is over-analysed.
- N/A: Descriptive case series / reports.

11. Some estimate of variance (e.g., confidence intervals, standard errors) is reported for the main results/outcomes (i.e., those directly addressing the study question/ objective upon which the conclusions are based)?

- Yes: Appropriate variances estimate(s) is/are provided (e.g., range, distribution, confidence intervals, etc.). Decision analyses: sensitivity analysis includes all variables in the model.
- Partial: Undefined “+/-” expressions. Or no specific data given, but insufficient power acknowledged as a problem. Or variance estimates not provided for all main results/outcomes. Or inappropriate variance estimates (e.g., a study examining change over time provides a variance around the parameter of interest at “time 1” or “time 2”, but does not provide an estimate of the variance around the difference). Decision analyses: sensitivity analysis is limited, including only some variables in the model.
- No: No information regarding uncertainty of the estimates. Decision analyses: No sensitivity analysis.
- N/A: Descriptive case series / reports. Descriptive surveys collecting information using open-ended questions.

12. Controlled for confounding?

- Yes: Randomized study, with comparability of baseline characteristics reported (or non-comparability controlled for in the analysis). Or appropriate control at the design or analysis stage (e.g., matching, subgroup analysis, multivariate models, etc). Decision analyses: dependencies between variables fully accounted for (e.g., joint variables are considered).
- Partial: Incomplete control of confounding. Or control of confounding reportedly done but not completely described. Or randomized study without report of comparability of baseline characteristics. Or confounding not considered, but not likely to have seriously distorted the results. Decision analyses: incomplete consideration of dependencies between variables.
- No: Confounding not considered, and may have seriously distorted the results. Decision analyses: dependencies between variables not considered.
- N/A: Cross-sectional surveys of a single group (i.e., surveys examining change over time or surveys comparing different groups should address the potential for confounding). Descriptive studies. Studies explicitly stating the analysis is strictly descriptive/exploratory in nature.

13. Results reported in sufficient detail?

- Yes: Results include major outcomes and all mentioned secondary outcomes.

- Partial: Quantitative results reported only for some outcomes. Or difficult to assess as study question/objective not fully described (and is not made clear in the methods section), but results seem appropriate.
- No: Quantitative results are reported for a subsample only, or “n” changes continually across the denominator (e.g., reported proportions do not account for the entire study sample, but are reported only for those with complete data - i.e., the category of “unknown” is not used where needed). Or results for some major or mentioned secondary outcomes are only qualitatively reported when quantitative reporting would have been possible (e.g., results include vague comments such as “more likely” without quantitative report of actual numbers).
- N/A: Should not be checked for this question.

14. Do the results support the conclusions?

- Yes: All the conclusions are supported by the data (even if analysis was inappropriate). Conclusions are based on all results relevant to the study question, negative as well as positive ones (e.g., they aren’t based on the sole significant finding while ignoring the negative results). Part of the conclusions may expand beyond the results, if made in addition to rather than instead of those strictly supported by data, and if including indicators of their interpretative nature (e.g., “suggesting,” “possibly”).
- Partial: Some of the major conclusions are supported by the data, some are not. Or speculative interpretations are not indicated as such. Or low (or unreported) response rates call into question the validity of generalizing the results to the target population of interest (i.e., the population defined by the sampling frame/strategy).
- No: None or a very small minority of the major conclusions are supported by the data. Or negative findings clearly due to low power are reported as definitive evidence against the alternate hypothesis. Or conclusions are missing. Or extremely low response rates invalidate generalizing the results to the target population of interest (i.e., the population defined by the sampling frame/ strategy).

Manual for Quality Scoring of Qualitative Studies

How to calculate the summary score

- Total sum = (number of “yes” * 2) + (number of “partials” * 1)
- Total possible sum = 20
- Summary score: total sum / total possible sum

Quality Assessment

1. Question / objective clearly described?

- Yes: Research question or objective is clear by the end of the research process (if not at the outset).
- Partial: Research question or objective is vaguely/incompletely reported.
- No: Question or objective is not reported, or is incomprehensible.

2. Design evident and appropriate to answer study question? (If the study question is not clearly identified, infer appropriateness from results/conclusions)

- Yes: Design is easily identified and is appropriate to address the study question.
- Partial: Design is not clearly identified, but gross inappropriateness is not evident; or design is easily identified but a different method would have been more appropriate.
- No: Design used is not appropriate to the study question (e.g. a causal hypothesis is tested using qualitative methods); or design cannot be identified.

3. Context for the study is clear?

- Yes: The context/setting is adequately described, permitting the reader to relate the findings to other settings.
- Partial: The context/setting is partially described.
- No: The context/setting is not described.

4. Connection to a theoretical framework/wider body of knowledge?

- Yes: The theoretical framework/wider body of knowledge informing the study and the methods used is sufficiently described and justified.
- Partial: The theoretical framework/wider body of knowledge is not well described or justified; link to the study methods is not clear.
- No: Theoretical framework/wider body of knowledge is not discussed.

5. Sampling strategy described, relevant and justified?

- Yes: The sampling strategy is clearly described and justified. The sample includes the full range of relevant, possible cases/settings (i.e., more than simple convenience sampling), permitting conceptual (rather than statistical) generalizations.
- Partial: The sampling strategy is not completely described, or is not fully justified. Or the sample does not include the full range of relevant, possible cases/settings (i.e., includes a convenience sample only).

- No: Sampling strategy is not described.

6. Data collection methods clearly described and systematic?

- Yes: The data collection procedures are systematic, and clearly described, permitting an “audit trail” such that the procedures could be replicated.
- Partial: Data collection procedures are not clearly described; difficult to determine if systematic or replicable.
- No: Data collection procedures are not described.

7. Data analysis clearly described, complete and systematic?

- Yes: Systematic analytic methods are clearly described, permitting an “audit trail” such that the procedures could be replicated. The iteration between the data and the explanations for the data (i.e., the theory) is clear – it is apparent how early, simple classifications evolved into more sophisticated coding structures which then evolved into clearly defined concepts/explanations for the data). Sufficient data is provided to allow the reader to judge whether the interpretation offered is adequately supported by the data.
- Partial: Analytic methods are not fully described. Or the iterative link between data and theory is not clear.
- No: The analytic methods are not described. Or it is not apparent that a link to theory informs the analysis.

8. Use of verification procedure(s) to establish credibility of the study?

- Yes: One or more verification procedures were used to help establish credibility/ trustworthiness of the study (e.g., prolonged engagement in the field, triangulation, peer review or debriefing, negative case analysis, member checks, external audits/inter-rater reliability, “batch” analysis).
- No: Verification procedure(s) not evident.

9. Conclusions supported by the results?

- Yes: Sufficient original evidence supports the conclusions. A link to theory informs any claims of generalizability.
- Partial: The conclusions are only partly supported by the data. Or claims of generalizability are not supported.
- No: The conclusions are not supported by the data. Or conclusions are absent.

10. Reflexivity of the account?

- Yes: The researcher explicitly assessed the likely impact of their own personal characteristics (such as age, sex and professional status) and the methods used on the data obtained.
- Partial: Possible sources of influence on the data obtained were mentioned, but the likely impact of the influence or influences was not discussed.
- No: There is no evidence of reflexivity in the study report.

Appendix D: Guidelines for Journal of Child and Family Studies

•Manuscript Style: All manuscripts should follow the recommendations of the 2019 Publication Manual of the American Psychological Association (Seventh Edition). Submissions should be formatted to print out double-spaced at standard 8" x 11" paper dimensions, using a 10 pt. font size and a default typeface (recommended fonts are Times, Times New Roman, Calibri and Arial). Set all margins at one inch, and do not justify the right margin. Double-space the entire manuscript, including title page, abstract, list of references, tables, and figure captions. After the title page,

number pages consecutively throughout including the reference pages, tables, and figure legends. Manuscripts should be no more than 30 pages in length, including all tables, figures, and references.

The Journal encourages the publication of research that is virtually jargon-free and easy to read. Thus, a personalized manuscript, written in active tense, is preferred. For example, “This study examined . . .” could be stated as, “We examined . . .” The Journal encourages a conversational rather than an impersonal tone in the manuscripts.

- Title Page:** A title page is to be provided and should follow APA-style. The title page should include the following elements: (1) the title (maximum of 15 words) (2) brief running head (50 characters or fewer) (3) full names of the authors (without degree). Use the form first name, middle initial, last name (e.g., John D. Doe) separated by a comma and the word “and” before the last author (4) author affiliation addresses. Use a lower-case superscript letter immediately after the author’s name and in front of the appropriate address. Provide the full postal address of each affiliation, including the country name. (5) corresponding author information. Include the corresponding author’s initials and last name (without degree), affiliation, mailing address, and e-mail address.

- Abstract:** The abstract should follow APA-style single paragraph format and should be not more than 250 words. It should be a concise and complete summary of the contents of the manuscript, without reference to the body of the paper. Per APA guidance, abstracts should cover key aspects of the literature review, the problem or research question(s), hypotheses, methods used (including design, measures, sample), results (major findings), and implications. Do not use sub-headings and do not cite references in the abstract.

- Key Words:** A list of 5 key words, separated by a comma, is to be provided directly below the abstract. Key words should address essential paper elements (research topic, population, method, and/or application of results/findings), as they are used for indexing purposes.

- Highlights:** Highlights are mandatory for this journal. Highlights capture the key, top-line messages of your research, for example novel results or new methods that were used during the study. Highlights should be included directly below the keywords on the same page as the Abstract. Please format highlights as 3 to 5 bullet points (maximum 85 characters, including spaces, per bullet point).

- Text:** Text should begin on the second numbered page and follow APA style. Authors are advised to spell out all abbreviations (other than units of measure) the first time they are used. Do not use footnotes to the text. When using direct quotations from another publication, cite the page number for the quotation in the text, immediately after the quotation. When reporting statistically significant results, include the statistical test used, the value of the test statistic, degrees of freedom,

and p values. In the discussion include an evaluation of implications (clinical, policy, training or otherwise). Also, discuss limitations in study design or execution that may limit interpretation of the data and generalizability of the findings.

- Footnotes: No footnotes are to be used.
- References Cited Within the Text: Cite references in alphabetical order within the text.
- References: The accuracy of the references is the responsibility of the authors.
- List references alphabetically at the end of the paper and refer to them in the text by name and year in parentheses.
- The style and punctuation of the references should conform to strict APA style – illustrated by the following examples:

Journal Article: Roelofs, J., Meesters, C., & Muris, P. (2008). Correlates of self-reported attachment (in) security in children: The role of parental romantic attachment status and rearing behaviours. *Journal of Child and Family Studies*, 17, 555-566.

Book: McBee, L. (2008). *Mindfulness-based elder care: A CAM model for frail elders and their caregivers*. New York: Springer.

Book Chapter: Singh, N.N., Winton, A.S.W., Singh, J., McAleavey, K., Wahler, R.G., & Sabaawi, M. (2006). Mindfulness-based caregiving and support. In J.K. Luiselli (Ed.), *Antecedent assessment and intervention: Supporting children and adults with developmental disabilities in community settings* (pp. 269-290). Baltimore, MD: Paul H. Brookes.

- Tables: Tables follow the Reference section. Tables should be submitted as editable text and not as images and should follow APA style. Tables that are a single column are actually lists and should be included in the text as such. Number tables consecutively using Arabic numerals in order of appearance in the text. Cite each table in the text and note approximately where it should be placed. Type each table on a separate page with the title and legend included.
- Figures: Figures follow the tables. Figures must be submitted in electronic form. Figures and illustrations (photographs, drawings, diagrams, and charts) are to be numbered in one consecutive series of Arabic numerals.

WoSRES
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Dear Miss Taylor

Study title:	The psycho-social experience of young refugees, families and their professional support system in relation to re-settling in Edinburgh, with a particular focus on wellbeing and access to suitable mental health services
REC reference:	18/WS/0237
Protocol number:	CAHSS1810/01
IRAS project ID:	253498

Thank you for your recent resubmission received on 9 January 2019, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information was considered in correspondence by a Sub-Committee of the REC. A list of the Sub-Committee members is attached.

We plan to publish your research summary wording for the above study on the HRA website, together with your contact details. Publication will be no earlier than three months from the date of this opinion letter. Should you wish to provide a substitute contact point, require further information, or wish to make a request to postpone publication, please contact hra.studyregistration@nhs.net outlining the reasons for your request.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Conditions of the favourable opinion

The REC favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements. Each NHS organisation must confirm through the signing of agreements and/or other documents that it has given permission for the research to proceed (except where explicitly specified otherwise).

Guidance on applying for HRA and HCRW Approval (England and Wales)/ NHS permission for research is available in the Integrated Research Application System, at www.hra.nhs.uk or at <http://www.rdforum.nhs.uk>.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of management permissions from host organisations

Registration of Clinical Trials

All clinical trials (defined as the first four categories on the IRAS filter page) must be registered on a publically accessible database within 6 weeks of recruitment of the first participant (for medical device studies, within the timeline determined by the current registration and publication trees).

There is no requirement to separately notify the REC but you should do so at the earliest opportunity e.g. when submitting an amendment. We will audit the registration details as part of the annual progress reporting process.

To ensure transparency in research, we strongly recommend that all research is registered but for non-clinical trials this is not currently mandatory.

If a sponsor wishes to request a deferral for study registration within the required timeframe, they should contact hra.studyregistration@nhs.net. The expectation is that all clinical trials will be registered, however, in exceptional circumstances non registration may be permissible with prior agreement from the HRA. Guidance on where to register is provided on the HRA website.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Ethical review of research sites

NHS sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	Version	Date
Copies of advertisement materials for research participants [Video Transcript]	Version 1	25 October 2018
Copies of advertisement materials for research participants [Poster]	2	20 December 2018
Covering letter on headed paper [Covering Letter]		
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Clinical Trial Liability]	Version 1	31 July 2018
GP/consultant information sheets or letters [GP Information Letter]	Version 1	25 October 2018
Interview schedules or topic guides for participants [Background Information Sheet]	Version 1	25 October 2018
Interview schedules or topic guides for participants		
IRAS Application Form [IRAS_Form_28112018]		28 November 2018
Letters of invitation to participant [Parent Invitation Letter]	1	20 December 2018
Other [EL Certificate]	Version 1	01 August 2018
Other [PL Certificate]	Version 1	24 July 2018
Other [Professional Indemnity Confirmation]	Version 1	31 July 2018
Participant consent form [Parent Consent Form]	2	20 December 2018
Participant consent form [Professional Staff Consent Form]	2	20 December 2018
Participant consent form [Young Person Consent Form]	2	20 December 2018
Participant information sheet (PIS) [Participant Information (Age 10-14)]	2	20 December 2018
Participant information sheet (PIS) [Participant Information (Age 15-18)]	2	20 December 2018
Participant information sheet (PIS) [Participant Information Parent]	2	20 December 2018
Participant information sheet (PIS) [Participant Information Professional]	2	20 December 2018
Research protocol or project proposal [Protocol]	2	20 December 2018
Summary CV for Chief Investigator (CI) [Chief Investigator CV]		16 November 2018
Summary CV for supervisor (student research) [Supervisor CV]		03 October 2018

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Reporting requirements

The attached document "*After ethical review – guidance for researchers*" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol

- Progress and safety reports
- Notifying the end of the study

The HRA website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website: <http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/>

HRA Training

We are pleased to welcome researchers and R&D staff at our training days – see details at <http://www.hra.nhs.uk/hra-training/>

18/WS/0237	Please quote this number on all correspondence
------------	--

With the Committee's best wishes for the success of this project.

Yours sincerely



for
Dr Stewart Campbell
Chair

Enclosures: List of names and professions of members who were present at the meeting and those who submitted written comments

"After ethical review – guidance for researchers"

Copy to: Ms Charlotte Smith, University of Edinburgh
Miss Melissa Taylor, NHS Lothian Research and Development Office

Lead Nation - Scotland: nhs.uk.NRSPCC@nhs.net

Interview Guide

NB: Based on translation restrictions, the wording of questions may need to be altered; however general topics will remain the same.

Young People

Questions will elicit an understanding of young refugees living in Scotland, their experiences of professional services and their perception of needs. Questions will broadly review the participant's experiences of resettlement before narrowing into the topic of mental health within the context of these experiences. Possible questions include:

Resettlement Experiences

- Where were you born? Where are you from?
- How long have you lived in Scotland?
- Who do you live with? (Family tree; names, ages, locations for further family interviews)
- Can you tell me about your life here in Scotland? (What is the best thing about being in Scotland? What do you think the hardest thing about coming to Scotland is?)
- What happened when you first arrived in Scotland? Are there any differences from when you first came to live here and now?
- What are the biggest differences between [home country] and Scotland?
- What would help you feel better living in Scotland?

Mental Health

- What do you think about what we call mental health? [Provide definition]
- How is mental health considered in [home country]? What happens in [home country] if people have mental health problems?
- What might make your mental health better/worse?
- Do you think your experiences have had an effect on your mental health, e.g. in home country, moving to Scotland, resettlement in Scotland?

Services

- Have you accessed professional services/charities?
- What might stop you from going to professional services?

IF SERVICE ACCESSED

- How did you hear about [service]?
 - What might stop you from going to [service]? Do you/ did you have any worries about it?
 - Can you describe a typical visit to [service]?
 - Is there anything positive/negative about your experiences with [service]?
 - Is there anything you would like to change about [service]?
-
- Is there anything else that you would like to comment on or talk about that I have missed?
-

Refugee Families

The researcher aims to be responsive to cultural sensitivities and adapt accordingly to ensure the comfort of participants; focus groups may consist of one whole family, or split into groups of mothers, fathers or siblings. Group members may feel uncomfortable sharing information; therefore each group member will also be given the opportunity to speak with the researcher individually.

Potential questions include:

Resettlement Experiences

- Where were you born? Where are you from?
- How long have you lived in Scotland?
- Can you tell me about your life here in Scotland? (What is the best thing about being in Scotland? What do you think the hardest thing about coming to Scotland is?)
- What happened when you first arrived in Scotland? Are there any differences from when you first came to live here and now?
- What are the biggest differences between [home country] and Scotland?
- What would help you feel better settled in Scotland?
- Do you know other refugee families? Are there things that other people have said to you they would have liked differently when they first arrived to Scotland? (no names)

Mental Health

- What do you think about what we call mental health? [Provide definition]
- What might make your mental health better/worse?
- Do you think your experiences have had an effect on your mental health, e.g. in home country, moving to Scotland, resettlement in Scotland?

Services

- What services have you been in contact with?
 - If no contact, what is limiting access to services?
 - IF SERVICE ACCESSED
 - What are your experiences of [service] in Scotland?
 - Has your child liked attending [service]? Have they found it helpful?
 - How has your contact with [service] helped/ not helped with life in Scotland?
 - Is there anything you would like to change about [service]? What would you like services to provide?
 - Is there anything else that you would like to comment on or talk about that I have missed?
-

Carer

Resettlement Experiences

- Can you tell me a little bit about how you got involved with caring for {unaccompanied minor}?
- Does he/she talk about the differences between life in Scotland and {home country}?
- What do you think he/she values most about being in Scotland?
- What do you value most about being a carer for him/ her?
- What do you think was the most difficult thing for him/ her about coming to Scotland?
- What do you think was the most difficult thing for you when caring for him/ her?
- Have you heard from other carers what they found most difficult?
- Are there things that would have made this process easier for both you and your child?

Mental Health

- What do you think {child's name} knows about mental health?
- Do you think he/ she has experienced any difficulties with emotions or psychological well-being? How has he managed these?
- Have you, as carers, experienced difficulties with your own well-being?
- What may have helped with you or your child's difficulties?

Services

- Has your child been involved with any professional services or charities to aid with resettlement or mental well-being?
- If no contact, what do you think might have got in the way of accessing services?

IF SERVICE ACCESSED

- What were his/ her experiences of {service}? Was it helpful or unhelpful?
- Is there anything you would change about the {service} or the care given?
- Is there anything else that you would like to comment on or talk about that I have missed?

Clinicians

The researcher aims to invite all staff members working closely with a young person to a separate focus group. If necessary, staff may be asked to provide written answers to the stated questions in their own time. This responsive approach aims to encourage participant recruitment and continuous engagement. The nature of questions will be tailored to the general refugee population, if the young person does not give consent to speak to caseworker. Possible questions may focus on the following areas:

- Thinking about the young people you've worked with, can you give me a general idea about the difficulties they face?
- Have you noticed any differences between working with young refugees and young people of the general population?
- Do you think there may be any barriers for young refugees and their families attempting to access services? Do you think there may be differences in what may prevent young refugees from accessing services that might differ from the general population?
- Do you have any concerns about working with young refugees and their families? (As an individual professional or for the service as a whole)
- Is there anything else that you would like to comment on or talk about that I have missed?

IF CLIENT HAS GIVEN CONSENT TO CONTACT CASE-WORKER OF A SERVICE.

- What is your current work with [patient]? (You do not have to go into detail)
- Does [patient] present with difficulties related to their refugee status and relocation to Scotland?
- Do you have much contact with {patient}'s family? What is the nature of this contact?

How do you feel about living in Scotland?

INFORMATION SHEET (10-14 YEARS)

Please ask an adult to help you

Leaving home and moving to another place can be hard. It is important for us to know how young people like you, feel about moving to Scotland.



Before deciding whether you want to answer questions, it is very important for you to know what you might be asked. Please take your time and talk to an adult about your choice.

Do I have to take part?

You do not have to answer questions if you don't want to. If you say yes, we will ask you and your parents/carers to sign a form. You can still change your mind later. If you do not want to take part, just say no.

You can tell us if we ask a question that makes you upset and we will stop straight away. You will still be treated the same, even if you decide not to answer questions or change your mind.



This is Alice.

What will I do?

Alice will invite you for an interview for one hour. Alice will ask if you want to do the interview alone or if you want another adult in the room, e.g. parent/carer or an interpreter. Alice will ask questions about you and moving to Scotland. She will ask questions about other adults you have met, like nurses or social workers.



We will keep your answers anonymous (no one will know what you said). We will have to talk to an adult, if we are worried about something you said. Some questions might make you feel a bit sad. If this happens, tell Alice, and she will stop asking questions.

We might also ask your family some questions. We might ask other people about you, like your social worker or nurse.

What happens next?

Alice will ask other people the same questions and add all your answers together. Noone will know what you said. Everyone's answers will be used to help people moving to Scotland.



Talk to us

If you want to ask any questions or speak to someone; please tell an adult and they can help you talk to us.

Call or text us at [07966278802](tel:07966278802)

Email us at alice.taylor@nhslothian.scot.nhs.uk

Complaints

If you want to make a complaint about this study, please contact NHS Lothian:

Patient Experience Team, NHS Lothian 2nd
Floor Waverly Gate, 2-4 Waterloo Place,
Edinburgh, EH1 3EG

Tel: 0131 536 3370

Email: feedback@nhslothian.scot.nhs.uk

Talk to someone else

If you want to talk to someone who isn't in the research team, please email

helen.griffiths@ed.ac.uk



How do you feel about living in Scotland?

INFORMATION SHEET (15-18 YEARS)



Leaving home and moving to a different country can be really difficult. We want to speak to 10 young people and their families about what it feels like to move to Scotland and what help you received.

Before deciding whether you want to participate, it is important that you know what the study is about and what you would be asked to do. Please take as much time as you need to read this information sheet and discuss it with others if you have any questions.

Do I have to take part?

You do not have to take part if you don't want to. You can think about your decision as long as you need to.



If you say yes, a researcher called Alice will ask you and your parents/carers to sign a form to agree to take part. You can still change your mind at any time and stop taking part. If you don't want to take part, just say no. There will be no changes to your care if you decide not to take part or change your mind later.

Your travel expenses for the interview will be given back to you

What will I do? How long will it take?

You will be invited to an interview with Alice. You can choose to do the interview alone or have another adult present e.g. your parent/carer or interpreter. We will ask some questions about you and how it feels being in Scotland. We might ask questions about what professionals you might have seen. It will take about an hour to ask these questions and your answers will be recorded.



Risks

We will try to make sure you feel comfortable through all the questions but it is important to let you know that some of the questions might make you feel a little upset. If this happens, it's really important to tell us and we will stop asking questions and make sure you feel better.

We would like to tell your doctor that you are taking part in the interview. We will keep your answers anonymous (no one will know what you said) unless we are worried about you, then we might have to tell an adult.

What happens next?

After the interview, Alice will listen to the recording and write down your answers. Only your parents/carers and some people involved in caring for you will know that you answered questions, but they will not know what you said. All information is stored in a safe place and only the research team will have access to it.

Alice will look at answers from everyone in the study and put them all together. The information will be written down and shown to people who might be able to help make it easier for people who might come to live in Scotland. We can also share this information with you and your family.



Talk to us

Call or text us at 07966278802

Email us at alice.taylor@nhslothian.scot.nhs.uk

Talk to someone else

If you want to talk to someone who isn't part of the research team, please email

Complaints

To make a complaint about this study, please contact NHS Lothian:
Patient Experience Team, NHS Lothian 2nd Floor Waverly Gate, 2-4 Waterloo Place, Edinburgh, EH1 3EG
Tel: 0131 536 3370 Email: feedback@nhslothian.scot.nhs.uk

If you wish to raise a complaint on how we have handled your personal data you can contact our Data Protection Officer who will investigate the matter.
Data Protection Officer, Governance and Strategic Planning,
University of Edinburgh, Old College, Edinburgh EH8 9YL
Tel: 0131 651 4114 Email: dpo@ed.ac.uk

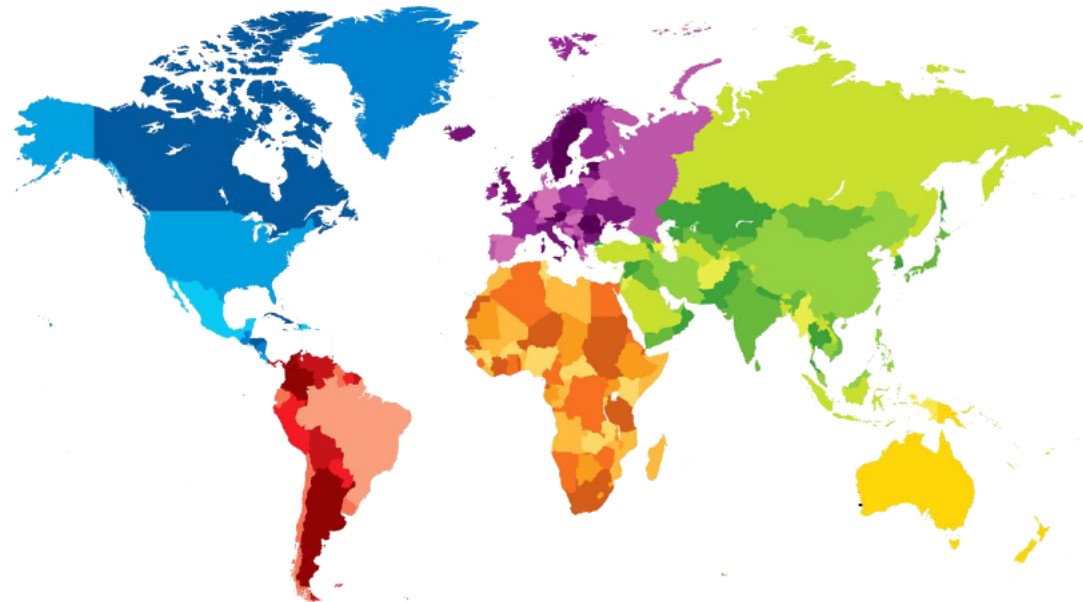
If you are not satisfied with our response or believe we are processing your personal data in a way that is not lawful you can complain to the Information Commissioner's Office (ICO) at <https://ico.org.uk/>

THANK
YOU!



How do you feel about living in Scotland?

INFORMATION SHEET (PARENT/CARER)



Why are we being invited?

We would like to invite you and your child to take part in a study about your experiences of moving to Scotland. Leaving your home and moving to another country can be really difficult.

We want to speak to 10 young people and their families about what it feels like to move to Scotland and what professional help you received. If you or your child have accessed any professional support teams, we would like to find out whether these services were helpful or how they could have helped you more. We would like to talk to you about the challenges you faced and what went well, to try to improve this experience for other people moving to Scotland in the future.

Before you decide whether you want to participate, it is very important that you know what the study is about and what you would be asked to do. Please take as much time as you need to read this information sheet and discuss it with others if you have any questions.



Talk to us

If you want to ask any questions or speak to someone;

Call or text us at **07966278802**

Email us at **alice.taylor@nhslothian.scot.nhs.uk**

Talk to someone else

If you want to talk to someone who isn't in the research team, please email **helen.griffiths@ed.ac.uk**

Complaints

To make a complaint about this study, please contact NHS Lothian:
Patient Experience Team, NHS Lothian 2nd Floor Waverly Gate, 2-4 Waterloo Place, Edinburgh, EH1 3EG
Tel: 0131 536 3370 Email: **feedback@nhslothian.scot.nhs.uk**

If you wish to raise a complaint on how we have handled your personal data you can contact our Data Protection Officer who will investigate the matter.
Data Protection Officer, Governance and Strategic Planning,
University of Edinburgh, Old College, Edinburgh EH8 9YL
Tel: 0131 651 4114 Email: **dpo@ed.ac.uk**

If you are not satisfied with our response or believe we are processing your personal data in a way that is not lawful you can complain to the Information Commissioner.
If you want to make a complaint about this study, please contact NHS Lothian:

Patient Experience Team, NHS Lothian 2nd Floor Waverly Gate, 2-4 Waterloo Place, Edinburgh, EH1 3EG

Tel: 0131 536 3370
Email: **feedback@nhslothian.scot.nhs.uk**



What will I do? How long will it take?

Your Child

Your child will be asked if he/she wants to take part in an interview with a researcher, called Alice. Your child will be given the choice of completing the interview alone or with another adult present, e.g. parent/carer or an interpreter. We will respect your child's wishes if they are happy to complete the interview alone. You will be asked to wait nearby. We will ask your child questions about how it feels being in Scotland. We might ask questions about what professionals you might have seen. This will take about an hour to ask these questions and their answers will be recorded.

We will also ask you if we can talk to other people involved in your child's care, like your nurse or social worker. We will ask them to answer questions about you, e.g. how many times have you met _____?



Risk

We will try to make sure your child feels comfortable throughout the questions, but it is important to let you know that some of the questions may be a little upsetting, e.g. talking about things that have been difficult about moving to Scotland. If this happens, we will stop asking questions immediately and make sure your child feels comfortable.

We will ask for your permission to contact someone (picked by you and your child) and the professionals involved in your care, if necessary.

What will I do? How long will it take?

You & Your Family

We would also like to ask you and your family some of these questions. You will be invited to speak to Alice in a group interview with the rest of your family or in separate groups of mothers and fathers. It is your choice who you want to be in this group. You can also talk to Alice individually if there is anything you do not feel comfortable speaking about in a group.

These groups will help us to have a better understanding of how it feels to move to Scotland and how professional services may be able to improve your care. These groups will last about an hour. If there are any questions that make you feel uncomfortable, you can choose not to answer. You can also withdraw from the study at any time without any consequences.

Questions might include:

How long have you lived in Scotland?

What happened when you first arrived in Scotland?

What has been difficult or good about moving here?

What happens after?

If you agree, we will ask you to write down your answers and the information collected about you will be kept confidential. We will only use the information for you if you agree. We will only use the information if you agree. We will only use the information if you agree.

There will be no changes to your care or the way you are treated if you decide not to take part in the study or change your mind during the study.

You can choose for your child to participate in the study even if you do not want to take part yourself.

What happens next?

After the interview, the researcher will transcribe the recording and the recording will be deleted. Your answers will be anonymised and confidential. All information is stored at a secure site and only the research team will have access to it. For general information about how we use our data please see

<https://www.ed.ac.uk/records-management/privacy-notice-research>

The results of the study will be distributed amongst involved professional teams, young participants and their families and any other appropriate party.

Talk to us

If you want to ask any questions or speak to someone; Please contact us:

Call or text us at [07966278802](tel:07966278802)

Email us at alice.taylor@nhslothian.scot.nhs.uk

Talk to someone else

If you want to talk to someone who isn't in the research team, please email helen.griffiths@ed.ac.uk

Complaints

To make a complaint about this study, please contact NHS Lothian: Patient Experience Team, NHS Lothian 2nd Floor Waverly Gate, 2-4 Waterloo Place, Edinburgh, EH1 3EG

Tel: 0131 536 3370 Email: feedback@nhslothian.scot.nhs.uk

If you wish to raise a complaint on how we have handled your personal data you can contact our Data Protection Officer who will investigate the matter.

Data Protection Officer, Governance and Strategic Planning, University of Edinburgh, Old College, Edinburgh EH8 9YL

Tel: 0131 651 4114 Email: dpo@ed.ac.uk

If you are not satisfied with our response or believe we are processing your personal data in a way that is not lawful you can complain to the Information Commissioner's Office (ICO) at <https://ico.org.uk/>

THANK
YOU!

How do you feel about living in Scotland?

INFORMATION SHEET (PROFESSIONALS)



We would like to invite you to take part in a study about how to best support people with refugee or asylum seeking status. We want to speak to 10 young people and their families about what it feels like to move to Scotland and what professional help they received.



We would like to talk to about their experiences and identify how these experiences may have impacted upon their emotional wellbeing. If the family have accessed any professional support teams, we would like to find out whether these services were helpful or how they could be improved.

As professionals who may be working with these groups, it would be really helpful to have an opportunity to discuss the unique challenges and benefits that may arise from working with people with refugee/asylum seeker status.

Do I have to take part?

You do not have to take part if you don't want to. The child and family can still participate in the study even if you do not want to take part yourself.

We will keep your answers confidential unless we are worried about yours or others safety; any risks will be addressed accordingly.

There are no direct benefits or risks to taking part in this study.



What will I do? How long will it take?

Child and Family

We will invite young people for individual interviews and ask questions about how it feels to move to Scotland; challenges and benefits. Their families will be invited to answer similar questions in a group. It is the families' choice who they want to be in this group.



Questions might include: *How long have you lived in Scotland? What happened when you first arrived in Scotland? What has been difficult or good about moving here?*

Families will be asked for consent to speak to professionals involved in their care, and consent to contact professionals in the event of distress or risk.



Professionals

We will invite you to speak in a focus group, about any identified differences between working with the general population, and those with refugee/ asylum seeking status. These groups will be audio-recorded. These groups will be organised at the convenience of participants and you will also be given the opportunity to speak to the researcher individually.

Questions may include: *Do you have any concerns about working with young refugees and their families? Do you feel that there are any specific differences in supporting young refugees compared with an individual from the general population?*



How do you feel about living in Scotland?

We would like to invite your child to take part in a research study looking at their experiences of living in Scotland. Your child will be asked to come to an interview for one hour. Your child can complete the interview alone or with another adult present e.g. parent/carer or interpreter. We will respect your child's wishes.

We will ask questions about how it feels being in Scotland. We might ask questions about what professionals you might have seen. For example, *"How long have you lived in Scotland?" "What is the best/worst thing about being in Scotland?"*

You and your child will receive more information about the study in the Participant Information Sheets provided.

Talk to us

If you want to ask any questions or speak to someone;

Call or text us at 07966278802


Email us at alice.taylor@nhslothian.scot.nhs.uk

CONSENT FORM



Participant ID: _____

Please
initial box

- I have read and understand the Information Sheet: V2 (20/12/2018). I have had time to think and ask questions ☐
- I know that I can stop answering questions at any time. I can say no to any questions  ☐
- (If applicable) I know that Alice will tell my GP that I am taking part, but not what I said in the questions ☐
- I know that some information collected may be looked at by people from NHS Lothian or University of Edinburgh. These people will check Alice's work. ☐
- I know that Alice will record my voice during the interview. She will delete it after she has written down my answers ☐
- I know that Alice will tell an adult if she is worried about something I say. It is OK if she talks to them before asking me questions to check that they can help me. ☐



Contact:

- (Optional) I know that Alice will ask to talk to me again about everyone's answers. She will also send me a summary of the study. I am happy with this. ☐



Contact:

- I agree to take part in the above study  ☐

Participant name

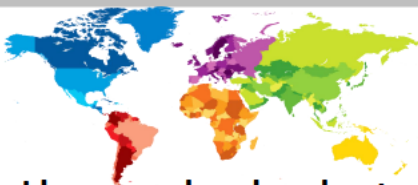
Participant signature

Date

Person taking consent


Date

CONSENT FORM



Participant ID: _____

Please
initial box

- I have read and understand the Information Sheet: V2 (20/12/2018). I have had time to think and ask questions ☐
- I know that I can stop answering questions at any time. I can say no to any questions  ☐
- (If applicable) I know that Alice will tell my GP that I am taking part, but not what I said in the questions ☐
- I understand that some people from NHS Lothian and the University of Edinburgh may look at some data from the study to check Alice's work. I give permission for those individuals to see my data. ☐
- I know that Alice will record my voice during the interview. She will delete it after she has written down my answers ☐
- I know that Alice will talk to someone (named) if she is worried about something I say. It is OK if she talks to them before asking me questions to check that they can help me. ☐



Contact:

- (Optional) I know that Alice will ask to talk to me again about everyone's answers. She will also send me a summary of the study. I am happy with this. ☐



Contact:

- I agree to take part in the above study

☐

Participant name and signature

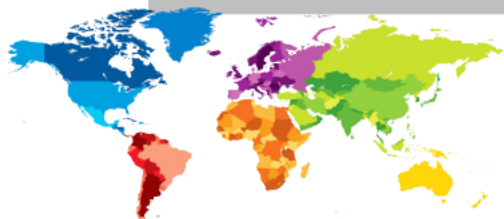
Date

Person taking consent

Date

CONSENT FORM

Participant ID: _____



Please
initial box

- I have read and understand the Information Sheet: V2 (20/12/2018). I have had time to think and ask questions ☐
- I understand that my participation is voluntary and I can withdraw from the study at any time. ☐
- I understand that relevant sections of data collected during the study may be looked at by individuals from the regulatory authorities and from the Sponsors (NHS Lothian and the University of Edinburgh) where it is relevant to my taking part in this research. I give permission for those individuals to have access to my record ☐
- I know that the researcher will record my voice during the interview. After transcription, this recording will be deleted. ☐
- I know my answers will be confidential and anonymous, unless the researcher feels there may be a risk to myself or others. ☐
- I agree to the researcher contacting me in the future to invite me to discuss the findings of the study. ☐



Contact: _____

- I agree to take part in this study ☐

Participant name and signature

Date

Person taking consent

Date

Copy to be retained in site file, Copy to be retained by participant



Are you a young person between 10-18 years old?

Do you have refugee or asylum seeker status?

We are interested in how you feel about living in Scotland and the support you received when you arrived. We want to understand how to improve services for people coming to Scotland.



We would like to invite you to an interview to speak about your experiences. This will last approximately 1 hour. We might also ask to talk your family or any professionals involved in your care

If you are interested and would like more information, please contact us.

Alice Taylor, Clinical Psychology Trainee



Tel: 07966278802

Email: alice.taylor@nhslothian.scot.nhs.uk

Appendix G: GP Letter



{Address}

{Date}

Dear **{GP/Professional}**

I am writing to inform you that **{Participant Name}** has agreed to participate in a research study looking at the experiences of resettlement by individuals with refugee/asylum seeker status. Their involvement includes the completion of an individual interview which should last approximately an hour. **{Participant}**'s family will also be invited to take part in a group interview to discuss their own experiences. If applicable, the study questions will also ask about **{Participant}**'s involvement with professional services; such as CAMHS or Social Services. Additionally, **{Participant}** will be invited to discuss their perspective on the findings of the research, which may last approximately 30minutes.

It is anticipated that there will be no risk to the individual as a result of participation in this study however it is important to note that due to the nature of the interview, there is a possibility that **{Participant}** may experience some emotional distress. Every effort will be taken to reduce the likelihood of distress by ensuring **{Participant}** understands their right to withdraw from the study at any time, and their right to refuse to answer any questions which makes them uncomfortable.

{Participant} has consented to the research team informing you of their decision to participate in this study. The research team have also been given consent to contact you in the event of emotional distress or a disclosure of risk to themselves or others.

I have enclosed the participant information sheets provided to **{Participant}** and their family. If you have any further questions, please do not hesitate to contact the research team on

Tel:

Email:

Yours Sincerely



BACKGROUND INFORMATION

Participant ID: _____

For the questions below, please fill in the answers or circle the answer that applies best. If you do not know the answers, just leave them blank.

AGE

I am _____ years old.

GENDER

Female Male Prefer not to say Other: _____

COUNTRY OF BIRTH

I was born in _____.

ETHNICITY

ARRIVAL IN SCOTLAND

I arrived in Scotland on ____/____/____

IMMIGRATION STATUS

Asylum Seeker Refugee Migrant Other: _____

CONTACT WITH SERVICES

I have been in contact with:

(FOR PROFESSIONALS ONLY)

SERVICE	DATE OF FIRST APPT	NUMBER OF APPTS
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>

Appendix H: Organisation Contact Table

The table below outlines all identified organisations in Edinburgh, both public and private sector, who were contacted to potentially participant. For confidentiality reasons, it is not specified which organisations took part in this study. Descriptions have been sourced from the organisations' websites/ leaflets, or summarised by the researcher.

Organisation	Description
Scottish Refugee Council	Independent charity which supports people in need of refugee protection in Scotland. They provide direct services including practical support, advice and a helpline. There is ongoing work with communities and community groups. Campaigning for policy and asylum system changes is a key part of their work. A recent addition to the website is an interactive map outlining refugee groups across Scotland.
The Welcoming Association	We welcome newcomers, build community and learn together. We do this by supporting newcomers to learn English, find jobs and access local services; offering opportunities for friendship, creativity, health and well-being in Edinburgh; connecting locals and newcomers through social and cultural exchange; collaborating with others to share knowledge and influence positive change
CAMHS Midlothian	Child and Adolescent Mental Health Services are the NHS service that assesses and treat young people with emotional, behavioural or mental health difficulties in Midlothian.
CAMHS East Lothian	Child and Adolescent Mental Health Services are the NHS service that assesses and treat young people with emotional, behavioural or mental health difficulties in East Lothian.
CAMHS North Edinburgh	Child and Adolescent Mental Health Services are the NHS service that assesses and treat young people with emotional, behavioural or mental health difficulties in North Edinburgh.
CAMHS South Edinburgh	Child and Adolescent Mental Health Services are the NHS service that assesses and treat young people with emotional, behavioural or mental health difficulties in South Edinburgh.
Edinburgh Connect	Edinburgh Connect is a mental health team for looked after and accommodated children and young people in Edinburgh. The service works with residential care staff and foster carers to promote and enhance the mental wellbeing of looked after and accommodated children (Discontinued)
ReAct Scotland	Re-Act, Refugee Action Scotland, is a not-for-profit humanitarian aid project launched in response to the worldwide refugee crisis. They collect donations for refugee camps across Europe. Support in Scotland include a Men's Group, Women's Group, Children's Group and Older People's Group amongst others.
Edinburgh College- ESOL	Our English as a Second Language (ESOL) courses are for people whose first language is not English. We also offer reading and writing workshops. Classes are in community centres, libraries, community high schools, and other community venues. We use a number of in-home volunteer tutors to assist

	those who cannot attend classes in the college or the community.
University of Edinburgh Chaplaincy	The Chaplaincy is a place of welcome, and offers social drop-in with tea and coffee, a relaxed space, opportunities for personal and spiritual development, and exploration of values worship, meditation, multi-faith and belief events, meals, debates and festivals links to volunteering opportunities meeting places for societies and religious groups
ReDefine	Refugee Emergency: DEFining and Implementing Novel Evidence-based psychosocial interventions (RE-DEFINE). RE-DEFINE is a scientific research financed by European Commission that aims to test the effectiveness of an innovative psychological intervention for preventing the onset of mental disorders in refugees and asylum seeker with psychological distress resettled in middle-income and high-income countries
CARA	The Council for At-Risk Academics (CARA) is an organisation dedicated to assisting academics in immediate danger, in exile, and many who choose to remain in their home countries despite the serious risks. In partnership with universities and research institutes, learned societies and other like-minded organisations, as well as many academics and other individuals, CARA offers practical and financial help, and assistance to reach a place where they can continue their work in safety. CARA rescues their families too
Saheliya	Saheliya is a specialist mental health and well-being support organisation for black, minority ethnic, asylum seeker, refugee and migrant women and girls (12+) in the Edinburgh and Glasgow area. Services include Counselling, Complementary Therapies, Practical and Emotional Support, group work, Outreach Work and Counselling, Learning Centre, Gardening Project, Childcare for under 7's to make sure women can access services
Police Scotland	Police Scotland provide protection of life and property, preservation of the peace, and prevention and detection of criminal offences. In the British model of policing, officers exercise their powers to police with the implicit consent of the public. They often interact with refugees and asylum-seekers in moments of crisis, often as victims of human trafficking or other crime.
Children and Family Services	They support families with complex needs and challenges -including domestic abuse, substance misuse and mental health issues ranging from intensive family support, specialist therapeutic work, conflict management and relationship support, and advice and wellbeing services
Refugee & Migration Programme Team	Refugee and Migration Programme Team seeks to assist, advise and, in some cases, financially support individuals who have a broad range of immigration related and 'no recourse to public funds' issues. This may include asylum seekers, victims of human trafficking, foreign nationals who are victims of domestic violence, some EU nationals, visa over-stayers, and other people subject to immigration control
Looked-After and Accommodated Children	Providing children in and on the edge of care with the support they need, when they need it, can help them to achieve their potential. This includes young people who have been removed from their family home for child protection reasons, due to placement breakdown or arrival to Scotland as an

Services	unaccompanied minor.
Mercy Corps	We support those affected by conflict in war-torn and neighbouring countries by providing emergency assistance to meet basic needs, creating safe spaces for youth, increasing economic opportunities and more.
Red Cross	The British Red Cross supports vulnerable refugees and asylum seekers in 58 towns and cities across the country. They offer care and support when people arrive in the UK after a political or humanitarian crisis. Supports include providing food and practical resources, benefits and career advice, health care, adjusting to life in the UK, orientation – getting to know your local area, emotional support and reuniting family (International Family Tracing Service).
NHS Meadows Child Trauma Team	The team works with children, young people, and their families who are experiencing emotional, behavioural and mental health difficulties following sexual abuse. They also provide a service for refugee and asylum-seeker children who have arrived to Scotland and may be experiencing mental health difficulties as a result of traumatic events in their past.
Schools	Five primary or secondary schools were contacted through Edinburgh Council.
Multi-Cultural Family Base	We are a social work organisation that believes in early intervention. We work to support children and parents dealing with important transition points – this can be the birth of a child, the move into primary school or the move to Edinburgh for families who are new migrants. We help children and families deal with issues of identity, loss, displacement and trauma. We work with families from a wide range of different communities, many of whom are deemed to be ‘hard-to-reach’. We value group work as a powerful tool for change and believe that groups can help children and adults find commonalities, a sense of belonging and community. All of our projects have started as small pilot projects built upon a perceived or known need from working in partnership with families and other agencies, e.g. Safe Haven
NHS Minority Ethnic Inclusion Project	Minority Ethnic Health Inclusion Project (MEHIP) provides free, confidential advice, information and support to black, minority ethnic and refugee communities. MEHIP has ethnic minority link workers and advocates who speak various languages and can help you to access primary health care services and perform an advocacy role regarding health services. The aim of the project is to improve the quality of and access to primary health care services by the black/minority ethnic and refugee communities across Lothian
Rivers Centre	The Rivers Centre is NHS Lothian's specialist service for people of all ages affected by psychological trauma. We are set up as a Public Social Partnership (PSP), working closely with our colleagues in health, social care and the third sector. This means that we are linked to a wide range of support services across Lothian.
Gate 55	Gate 55 is a community hub providing library and support services, clubs for all ages, parent groups, exercise classes and access to learning, training, and employment. Activities range from Everyday English to Book Clubs and Homework help
GLIMER	The aim of the GLIMER project is to work towards innovative solutions that will

	help European cities and regions facilitate the long term inclusion of displaced people in a way that remakes local spaces. Our goal is to generate theoretically informed but empirically grounded data that is able, through best practice sharing and reporting, to inform and collaborate with policy-makers and stakeholders on how workable approaches can be found to the mutual integration of displaced migrants and refugees, but in a manner that re-makes local spaces.
Open Arms Project	The Open Arms Programme is a collaborative project between ELREC, Sikh Sanjog, LINKnet, and Saheliya. It is designed to engage minority ethnic and migrant women in Edinburgh and the Lothians. Each collaborating organisation offers a variety of women-only services and activities. We offer fitness and sports classes as well as classes, such as yoga, which help one cope with mental health stresses such as anxiety and depression. Furthermore, we deliver activities aimed at personal and creative development such as arts and crafts and creative writing.
Leith Links	Leith Links Counselling Service provides confidential and professional counselling to all members of our diverse community. It is our heart that no one journeys alone through a difficult time of life. We offer professional counselling support within the community, making counselling accessible to all.
Universities of Sanctuary- University of Edinburgh	Higher Education Institutions in the UK have a proud and radical tradition of providing sanctuary for academics and young people. City of Sanctuary has partnered with Article 26, Student Action for Refugees and others to develop a network to inspire and support universities to develop a culture and a practice of welcome within their own institutions, in their wider communities, and across the Higher Education sector in the UK. A growing number of these universities are now being recognised as Universities of Sanctuary.
Migration Scotland	Migration, Population and Diversity team has responsibility for policy issues relating to migration to Scotland in all its forms (including asylum seekers and refugees), human trafficking, population and demographic change, and also provides oversight of equality and human rights issues. It is one of a number of local authority-led Strategic Migration Partnerships based across the UK and works with partners from across the public, private and voluntary sector as a means of ensuring that Scotland is a welcoming place for new migrants.
Ethnic Minority Law Centre	The Ethnic Minorities Law Centre offers legal services exclusively to people from ethnic minority backgrounds, and specialises in discrimination and immigration issues. The Law Centre operates a telephone helpline and appointment system.
Skills Development Scotland	Skills Development Scotland (SDS) is Scotland's national skills body. We contribute to Scotland's sustainable economic growth by supporting people and businesses to develop and apply their skills. We work with our partners to provide services that deliver the very best outcomes for Scotland's people, businesses and the economy
Refugee Rights Europe	We are working to ensure that asylum accommodation provision in Britain is humane and attains reasonable standards in terms of hygiene, safety and

	comfort. We advocate for Youth Welfare Officers to be provided in all Home Office provided asylum accommodation, to cater to the physical and mental health of 18 to 25-year-old asylum applicants seeking sanctuary in Britain. We are part of a wider movement calling for an end to indefinite immigration detention and the use of alternatives to detention
SCORE Scotland	Strengthening Communities for Race Equality Scotland (SCORE Scotland) is a voluntary organisation serving the minority ethnic communities in the West of Edinburgh. The organisation strives to eliminate racism in our society by working for and with those who are affected by racial discrimination. Ongoing services include youth groups, one to one support, multi-cultural activities and events.
Colours of Edinburgh	Our mission is to create a platform for newcomers seeking refuge to share their stories through art, research, and digital media in order to challenge negative misconceptions. We are a student and graduate-led social enterprise working towards: <ul style="list-style-type: none"> -Challenging negative misconceptions of refugees and asylum seekers through art, digital media, and educational events -Aiding newcomer integration through creative community building -Raising funds for local charities working to build better lives for refugees and asylum seekers
STTEPS	Syrian Teenager Tutoring and Educational Programme (STTEPS) began in the wake of the Syrian crisis. We were prompted by feelings of compassion for Syrian refugees who had suffered great loss and there was a desire to respond and act by befriending and tutoring the teenagers of Syrian refugee families who were newly arrived in Edinburgh. They had arrived in Scotland seeking refuge from war and conflict and looking for new beginnings from oppression which took away their opportunities for education and freedom. Many who joined STTEPS as volunteer student tutors have come from the BAME community in the University.
Edinburgh Together	Edinburgh Together brings the passion, skills and expertise of Barnardo's Scotland, Children 1st and Canongate Youth to supporting children and young people aged 0-18 and their families. Working together with families, communities and Edinburgh Council to make Edinburgh a truly child-friendly city. Services include a helpline, signposting to professional help, group-based activities and support for educational attainment.
6VT	6VT provide a safe social space for people aged 15 and over in Edinburgh. It provides a drop-in service which is open three nights a week, providing a range of personal development support, educational workshops, advice and information. It now also provides housing services and an integrated community support service for young people facing the prospect of foster care, residential care or being housed in a secure unit
Refugee Youth Edinburgh	Refugee Youth is dedicated to improving the lives of young refugees aged 14-20 at different points in their journey. We focus on increasing emotional wellbeing and reducing social isolation amongst young newly arrived asylum

	seekers. All our work is underpinned by collaboration, creativity and community building. Young people inspire and support each other to lead their own projects, youth groups and activities, to improve their own lives and those of their peers
Wellspring	Wellspring is a leading Centre for the provision of affordable high-quality psychotherapy and counselling to individuals; couples, groups, families and young people. Support also includes practical advice, befriending, advocacy, EFT and EMDR.
Edinburgh Joint Integration Board	The Edinburgh Integration Joint Board (EIJB) for Edinburgh Health and Social Care Partnership is made up of representatives from City of Edinburgh Council and NHS Lothian, Third Sector representatives, service users and carers. The Edinburgh Integration Joint Board, through its Chief Officer has responsibility for the planning, resourcing and the operational oversight of a wide range of health and social care services.
Rock Trust	Our aim is to end youth homelessness in Scotland by ensuring that every young person has access to expert youth specific services to assist them to avoid, survive and move on from homelessness. We advise, educate and support young people to enable them to build the personal skills and resources required to make a positive and healthy transition to adulthood. We also work to ensure that the public, policy makers, commissioners and practitioners understand the issues, make decisions and take action to end homelessness.
Edinburgh and Lothians Regional Equality Council	The main objectives of ELREC are to work towards the elimination of discrimination in all its forms-to reduce inequality and promote a culture of human rights. They aim to promote and organise cooperation in the achievement of the aforesaid purposes and to that end to bring together in ELREC, representatives of the statutory authorities and voluntary organisations within the Local Authority Council, areas of the City of Edinburgh, East Lothian, Midlothian and West Lothian
Health in Mind	Our approach is built on three main principles: Person Centred, Trauma Informed and Strengths Based. We provide group activities, one to one support and a helpline
The Junction	Phone, text or email support for young people in Edinburgh aged 12-21. Have a free confidential one-to-one chat with a worker for around half an hour about anything on your mind. All our workers are really friendly and will treat you with respect. The worker can listen to you, work with you to think about what might help and help you find any information you might need
LINKnet	LINKnet Mentoring Ltd is a mentoring organisation, established to serve minority ethnic communities in Edinburgh, the Lothians, Scottish Borders and Fife. It was established in 2000 to serve disadvantaged ethnic minorities in their pursuit of development. Over the years, thousands have taken part in various mentoring programmes, education and employment mentoring being the core programmes.
Edinburgh School of	Edinburgh School of Language delivers quality English language courses to students from around the world. If you want to improve your English to get a

Language	better job, apply for a university course, we can help! Our effective, practical, modern and reliable approach to students benefits all candidates in achieving their goals. We offer a wide range of language courses
Amnesty International	We are Amnesty International UK. We work to protect people wherever justice, freedom, truth and dignity are denied. We investigate and expose abuses, educate and mobilise the public, and help transform societies to create a safer, more just world.
Intercultural Youth Scotland	Intercultural youth Scotland is a grassroots, youth-led charity in Scotland. We are the leading organisation to deliver evidence of meaningful and genuine engagement and impact for Black, Indigenous and People of Colour Young Scots (BIPOC) in Scotland. We lead in Youth Anti-Racist Activism and Anti-Racist education in Scotland and services. We deliver crucial, effective and culturally appropriate youth provision for 13 – 24 year olds, making an impact on fairness in employment, positive destinations through the vehicle of performing arts and events.
Scottish Faith Action for Refugees	Scottish Faiths Action for Refugees is a project which seeks to co-ordinate and promote action by faith communities in Scotland to support asylum seekers and refugees. In Edinburgh, we lead a local integration project for refugees and people seeking asylum
Syrian Futures	Syrian Futures is led by a Syrian member of staff at the University of Edinburgh to help Syrian Refugees access higher education and employment. Through the project, we create opportunities to engage the Syrian community with the University of Edinburgh students and facilities to improve their experience living in Edinburgh. We work together to identify opportunities to improve their skills, engage them with, and contribute to the community.
Edinburgh Mosque	We are a mosque of sanctuary & compassion. We encourage all to embrace their Islamic faith and provide outreach groups for youth. We aspire to this vision through a dedicated ethos of serving Edinburgh through our space, our facilities, in our outreach activities and especially through knowing and understanding each other.
Edinburgh Churches for Sanctuary	Edinburgh Churches for Sanctuary is a network of churches seeking to develop Edinburgh as a welcoming city for refugees and asylum seekers. We work to improve the welcome of refugees and asylum seekers across the UK. We invite churches across Edinburgh to participate in this work and we are keen to work with other faith and non-faith organisations that share our aims and vision
Refugee Survival Trust	We provide refugees and people seeking asylum with practical support when it is most needed, build connections between people and use what we learn to campaign for change

Appendix I: Transcription Key

Transcription Key:

R: Researcher/ interviewer speaking

...	Pause - if a clearly perceptible pause is present. Duration not recorded
,.!?	Punctuation indicates speaker's natural intonation
.	Period – stopping fall in tone, indicating the end of a sentence
,	Short pause as part of rhythm in the speech
!	Exclamation – an exclamation mark at the end of a word indicates it is uttered louder than surrounding speech
?	Rising intonation – a question mark at the end of a word indicates a rising intonation (not necessarily a question)
<i>(italics)</i>	Transcriber's description of participant's non-verbal gestures is indicated by description in italics font and parentheses
<i>(language)</i>	Language used in interview- where the participant is speaking in a language other than English, this is indicated before speech. Indication of a return to English will be indicated similarly
<i>(unclear)</i>	Uncertain transcription – if speech is unclear, but still probably accurate, this is placed within parentheses and italics. Time-point also recorded
<i>(interruption)</i>	Overlapping speech – if speakers speak simultaneously, this is indicated and intelligible speech is recorded
<i>(unintelligible)</i>	Speech left out - if the speech is unintelligible. Time-point also recorded
{redacted}	Identifiable information removed from text- indicates the nature of the information, e.g. name of school
<u>Under</u>	Emphasis – if a word or phrase is emphasised, it is underlined

Appendix J: Example of Annotated Transcript

How much must he miss them?	1: Yeah so of course, from early doors I knew that he had	Loss & Longing- Missing family
How does he feel that he has had to leave them behind?	home, he had <u>grandparents</u> at home and he had a brother	
Do we have an understanding of how far he has been?	and we looks up <u>maps</u> , Google! maps so he could show me	
Social worker role emerging here from Lauren?	lived {town name} is the name of his town and you'll of co to anonymise parts of this or else it'll be, not confidential	
Is this how we can begin to talk about home countries, culture and heritage? As in Hughes, 2014?	R: Yes of course, it needs to be confidential, I will be taking	
Curiosity and openness from carer	names and places	
Short, superficial chats- little by little- are services set up to support this type of 'processing'?	1: Yeah and the two other towns then so a sort of triangle	Loss & Longing- Showing home to 'new family'
How do we get a sense of anything when everything is so different?	{town name} where his mums family are from, {town name} his eh ... father's family are from and {town name} the town	
Humour in storytelling	they live is a sort of triangle which is probably round roughly	
Cultural differences re gender roles, family roles, age of marriage- Research	10ish meters, 10 miles or so from the other, em, he you know	
What would life and university been like if he had stayed?	looked up Google maps as much as we could to to you know	Connection & Disconnect- Connections to home?
	where these places were, and he could show me and he could	Loss & Longing- Everything is different re culture, lifestyle
	<u>little</u> bit about what his his house looks like although I don't	
	have much of a sense of that? and about his <u>mum</u> , and he	
	quick to tell me that he granny was younger than me (<i>laughter</i>)	
	R: Ouch (<i>laughter</i>)	
	1: So it doesn't surprise me because they do get married and	Loss & Longing- What could my life have been like, if I stayed?
	children so young and his granny is in her early 50s or something	
	yeah em... then... em, so, eh what else? Just em (<i>sigh</i>) just	Identity- Who could I have been?
	school and what kind of university would have been if he'	

Carer taking young person's lead

Don't dwell on it- as a coping strategy?

Considering themselves as family unit 'as a family'

Being open and curious- trauma informed working?

Acknowledging difficulties and the loss of Mum at these moments- giving space and opportunities to talk about home

Needing emotional support

Still a child, despite what he has been through

Event happened near start of caring relationship

Described as little 'glimpses' into another life

Is he worried about family, hoping for peace so he can go home?

Potentially triggering re traumatic experiences, family safety

Some way of keeping connected to home

Sense of injustice that he got a peace prize?

Chance of hope and dashed with another corrupt government

there and em... so he would talk in the abstract about all of these kind of things mmhmm you know? ... and tell me a little bit about his brother and his sister and em... I didn't dwell on it, he didn't dwell on it, we didn't dwell on it as a family I suppose, we, and he didn't, but whenever he would talk about it, we listened and ask questions and em... the times when, em particular critical times when I would say you know awk I just wish we could be in touch with your Mum were when he did really well in school, when he passed his driving test, (*gasp*) when he, he broke his collar bone playing football and we, he was sitting in A&E all night for hours on end and he was crying and I, it was just a horrible horrible time and I just remember thinking, aw I just wish your Mum was here and saying that to him and that, and that, just , you know that's hard you know, he's still only a wee boy at the time, you know, still only early doors, 16 or 17 when that happened and em just eh... em... times like that. So we would, we would get little insights into, as I say say, we would talk about what punishment in a classroom would look like and stuff like that so we would get little insights into that sorta thing, and and you know he was following news items and stuff about the political situation and the unrest or whatever and so he would tell me when, you know he would say oh things have kicked off again, and there's more protests and he would show me a little video that he'd found on a website and about the unrest and he would recognise places or whatever from that em, so he was keeping on top of what was going on politically and then of course there was the change in prime minister so there was all sorts of hope about this was going to be the new way, this guy had won the Nobel Peace Prize and there was gonna be a new wave of, everything gonna be so much better and of course

Meeting Needs- Managing feelings

Meeting Needs- Trauma informed approach?

Vocational Discord- Carer feeling upset at child's circumstances

Connection & Disconnect- Carer trying to connect emotionally with young person

Identity- Still only a wee boy

Unknown & Uncertainty- getting little insights but no general sense

Trust & Safety- Checking on news for family safety/ potential of going home?

Loss & Longing- Chance at returning to the future he originally had?



SUMMARY OF RESULTS

I talked to young people and families about how it feels to leave their home country and move to Edinburgh. I also talked to people who worked in the NHS and/or charities who support people with refugee or asylum-seeker status. It is important that people know what it is like to resettle in Edinburgh and how we can help to make this process easier. We found out lots of things.

- Young people and mothers miss their friends and family. They worry about everyone back home.
- We talked about how hard it can be to live in a different country because of a different language, weather and culture.
- It was also difficult to make friends and find out about activities around Edinburgh
- Sometimes this made people feel angry or sad or lonely and it was hard to talk to about these feelings
- We talked to staff members who said they want to help but sometimes they didn't know how to provide the best support.
- Young people and mothers told us that there were things that Edinburgh could change to help them feel better
 - More support with making Scottish friends
 - Permanent housing
 - More advice about legal processes
 - One person to talk to that could help with all difficulties
- Staff also told us things that would be helpful to change
 - More links with other teams to work better together
 - More knowledge about different cultures e.g. training
 - More guidance around how to focus on the present and young people's strengths



Appendix L: Themes and Subthemes (Each Participant Group)

Young Person Participants

<u>Theme</u>	<u>Sub-Theme</u>	<u>Hassan</u>	<u>Mohammed</u>	<u>Amira</u>	<u>Waseem</u>	<u>Ahmed</u>	<u>Saad</u>
<i>Trust & Safety</i>	It's not safe to stay in Syria	✓			✓	✓	✓
	Worry about safety of family left behind	✓	✓		✓	✓	✓
	Putting trust in asylum process	✓			✓	✓	✓
<i>Connection & Disconnect</i>	It was hard for me to make friends	✓	✓	✓	✓	✓	✓
	It takes time to adjust	✓	✓	✓		✓	✓
	Connections with home	✓		✓		✓	✓
<i>Loss & Longing</i>	I miss home and everything about it	✓	✓	✓	✓	✓	✓
	I didn't see my childhood				✓	✓	
	Everything is so different	✓	✓	✓	✓	✓	✓
	Managing feelings	✓	✓	✓	✓	✓	✓
<i>Meeting Needs</i>	Scotland has helped me	✓	✓	✓	✓	✓	✓
	I just had to learn myself- no one could help us		✓	✓	✓	✓	✓
	Access to services		✓	✓	✓	✓	
	Yeah, I didn't go to school	✓	✓		✓	✓	✓
	Unmet Needs	✓	✓	✓	✓	✓	✓
<i>Identity</i>	Sense of determination	✓	✓	✓	✓	✓	✓
	This is my country	✓	✓	✓	✓	✓	✓
	We are refugee here	✓	✓		✓	✓	

Family Participants

Themes	Sub-Themes	Fareeda	Raheef	Fatima	Aisha	Sabah
<i>Trust & Safety</i>	I don't know what situation she is in	✓		✓	✓	✓
	This was the last time knocking on doors	✓			✓	✓
	They think it will be difficult to return us				✓	✓
<i>Connection & Disconnect</i>	It's a big barrier between us			✓	✓	
	I can't separate work and personal life					✓
	Difficult to move to new house and start again	✓		✓	✓	✓
<i>Loss & Longing</i>	There is a lot different	✓	✓	✓	✓	✓
	At last I said come illegally	✓			✓	
	We can't forget about them	✓		✓	✓	✓
<i>Meeting Needs</i>	They just help you	✓	✓			✓
	I have financial problems	✓		✓		✓
	So can you help me?			✓		
	The children are different ages		✓	✓	✓	✓
<i>Identity</i>	Everything is my responsibility	✓				✓
	Islam	✓		✓		✓
	She is Scottish		✓		✓	✓

Staff & Carer Participants

Theme	Sub-Theme	Service 1	Service 2	Service 3	Carer
<i>Trust & Safety</i>	Not what indirect workers are expecting	✓	✓		✓
	Never to talk about that stuff	✓	✓	✓	✓
	They're set up to have distrust	✓	✓	✓	✓
	Relationships on a sound footing	✓	✓	✓	✓
<i>Connection & Disconnect</i>	Parents disconnected from their child	✓		✓	
	How trauma is conceptualised in other cultures	✓	✓	✓	
	Not had the same boundaries	✓	✓	✓	✓
	Food and hospitality are very important culturally		✓	✓	✓
<i>Meeting Needs</i>	They just need to feel safe	✓	✓	✓	✓
	Services then can't change	✓	✓	✓	
	That anxiety from the key worker	✓	✓		
<i>Identity</i>	Who am I and where do I belong?	✓	✓	✓	
	Projection of vulnerability	✓	✓	✓	✓
	Different narratives on resettlement has different effects	✓	✓		✓
	Dependent cultures versus independent cultures	✓	✓	✓	✓
<i>Unknown & Uncertainty</i>	On their own in an alien culture	✓	✓	✓	✓
	A real sense of the unknown	✓	✓		
	Can they stay?	✓	✓	✓	✓
	Guidance is not clear	✓	✓	✓	✓
<i>Vocational Discord</i>	It hits the personal stuff	✓	✓	✓	✓
	What's important here?	✓	✓	✓	✓
	Vast polarisation in different approaches	✓	✓	✓	✓
	Not as linked to services as we could be	✓	✓	✓	

Appendix M: Individual Case Analysis

Young Person 1 (Hassan)

<u>Theme</u>	<u>Subtheme</u>	<u>Quote</u>	<u>Location: Page (lines)</u>
<i>Trust & Safety</i>	I don't know whether I will die We're not safe	We have a war in Syria, it's not it's not good life to stay there, it's not safe to stay there. Maybe don't know what time you will die too or if you walk on the street, you will find some people died. I don't know what happen, dangerous area, it's not safe area to stay	2 (22-24)
	Here is safe	Like, its better here, like, its better because I'm coming to this place, here is a safe place so yeah Of course, like we all get upset because we left our country so yeah, but we were happy because we coming to here. Here is safe and space here.	11 (207-208) 12 (231)
	We have been trying to get to UK	Yeah no my parents wanted to come to here, but you know we couldn't to come to here so time to time we try to come here and after that we come here [] We come here by United Nations, yeah they send us to here. Yeah they offer to us, would you like to go to Britain, yeah we would like we are trying, have been trying for a long time to get this one, so yeah	1 (27-31)
	We don't know where we are going	Just difficult when you travelling to here, [] difficult because we don't know where we are going so that's why, yeah we don't know where we are going. We know about like just we are going to Britain but to where we don't know so	4 (75-76)
<i>Connection & Disconnect</i>	Making friends	I have from Syria and I have friends from Scotland [] Like I see them {Syrian friends} when eh, we have like a celebration or, I see them and I just say hi, speak with them so I start know them yeah	10 (183-184)
	I don't understand them	I don't know how to speak with them so I wouldn't speak English so you know it was hard and difficult for me so when I used to learn English and start a bit to talk with people, it a bit more easy for me so yeah [] Because I wasn't speak English so when the people speak with me, I don't understand them, yeah. I get frustrated too	8 (157-161)
<i>Loss & Longing</i>	Three jobs as a child	I have three jobs actually. I am a tiler and a barber and eh I make Arabic food, like a chef. I used to work in Syria and Lebanon, [] Yeah 12 {years old}, eh 12 or 13. Like my brother, he had a big factory, he is a tiler, so he started learning me like how to, you know to do things and I start learn from him. And when we have spare time off, like from high school, I go with my brother and I learn from him	7 (128-129) 8 (140-142)
	I miss home and	We are upset because we left our country. Of course, everyone when you change your country so,	11 (209, 216-

	everything about it	when you get upset yeah [] (<i>tearful</i>) Everything, everything, friends, family, most of family, my family's (<i>voice break</i>) died there so yeah	217)
	Separated families	I have two sisters in {redacted} still in Syria, and I have here one in Scotland [] It's hard to come to here, they can't [] they would like but they can't	6 (104)
	We all feel the same	Yeah of course, all the family we feel the same. I spoke to my brother and say did you understand and he say no I don't understand	9 (165-166)
<i>Meeting Needs</i>	It's not talked about	It's not really talked about, it's a closed subject [] I'm worry about them, the people like, you know that have this	14 (266)
	Initial impression	since I got here actually It was, I was exciting, yeah I was exciting and yeah really happy because I come to here'	6 (114)
	If you don't like it, you can't stay	They {family} like it here also. If they don't like it they can't come to here so. Yeah we like it here that's why we stay here	3 (52-53)
	Quite difficult to get a house	I just worried that we hear like one small mistake when we arrived to here, so we have quite difficult to get a house here. Houses, it is very difficult to get a council house. [] It takes 4, 5, 6 years, yeah to get a house, to get as council house yeah [] so like when you apply to the council, the council will give you like a house so but it takes a long time to get a house, so this is a big problem yeah.	15 (299-306)
	They provided everything	They help since we, they have been provided everything for us since we come to here [] Yeah I'm happy with the government. I give thanks for the government because they are been providing everything to us since we come to here so education, everything, houses. They provided houses when we come to here so yeah	13 (245-247)
<i>Identity</i>	Education is so important	So important things like education so important and the life yeah [] I'm going to start studying, I have like ambitions to study, yeah I was very happy that I come to here, so I can continue studying	3 (50) 6 (116-117)
	I'll study and work as a job	So I want, the first thing I want, I would like to mastering my English. After that I can work, like choose one subject and study it, at college or university, yeah Ill study and work as a job [] Yes of course it depends about how, the subject, which one I want to choose or if I can study here in college, I may study, keep studying here. So if I need to move to university so I will move to there	9 (119-120) 18 (344-346)
	We have a new life here	I don't have anything like there to do maybe I will come back there for visiting, no more, because my life, we have a new life here. My life is finished in Syria so nothing, like I don't have something to do there, nothing to do there [] Yeah maybe to visit. I don't like, I don't have ambitions there	18 (353-356)

Young Person 2 (Mohammed)

<u>Theme</u>	<u>Subtheme</u>	<u>Quote</u>	<u>Location:</u> <u>Page (lines)</u>
<i>Trust & Safety</i>	Asylum Process	Maybe, if the war will not finish, we could get nationality and I would stay	6 (103)
<i>Connection & Disconnect</i>	Time	it just takes time yeah, it just takes time [] Just when, yeah, when I knew more about what life in here, about what people think	13 (243) 9 (178)
	If you learn English, you get friends	I think the biggest problem was the language. If people can learn the language then I think people will be OK and they can do everything. You can get friends	13(243-244)
	I stayed at home	But first I stayed at home doing nothing, I wasn't speak never English [] maybe 2 ... or 3 months {circumstance changed} maybe when I'm getting better in English and start at in the school. And then I got more friends and yeah so	6 (109-114)
	Lifestyle changes	When I came I was like this because we didn't be used to this. It was always like hot and 47/45 degrees, something like this [] I get white now, (<i>indicating bare arm</i>) I didn't used to stay at home all the time (<i>laughter</i>) Yeah I was in Jordan like that {always outside}	2 (29-32) 7 (120)
<i>Loss & Longing</i>	I don't know my own country	Syria maybe because I know not much about it, so I just like to know more. It is still my country	8 (143-144)
	I want to go home	maybe {worst bit} if we don't go back to our countries [] when they have finished the war [] Because I was come from there, I was born in there,	5 (90-94)
<i>Meeting Needs</i>	It was very hard for my Mum	Yes I think for the same reasons [] Yes, especially my mother, it was very hard to her. To learn English and yes nowhere to go. And she always talk to my sister	8 (158-159)
	Makes me feel sad and angry	yeah, sad because like I said, it was a big difference to our country, to Jordan also yeah [] when I wasn't speaking English, when I didn't understand people, then of course it makes me angry	7 (136-139)
	Don't want to talk	Yeah but it just, maybe I don't want to talk to that and maybe it go away	10 (186)
	More social activities	Maybe because I only got to school on January, maybe more activities to do, yeah {over a year since arrival}	2 (37)
	Word of mouth	I had an appointment with a dentist and he was my interpreter [] he told me about this group	11 (200)
<i>Identity</i>	Giving back to Scotland	No, and they are helping. They help me, they help me for that long and I like to like to give Scotland as they give me	12 (234-235)
	Good jobs	Maybe because afterwards, I go to university, I get good jobs in here. But I think from all the world people come to here because lots of good jobs in here [] very important	5 (82-83)

Young Person 3 (Amira)

<u>Theme</u>	<u>Subtheme</u>	<u>Quote</u>	<u>Location: Page (lines)</u>
<i>Trust & Safety</i>	It's safer	Well I would say happy about it and... well because it's safer and... there's a better future for us	2 (33)
<i>Connection & Disconnect</i>	Arriving to Edinburgh	I came on {exact date} [] we took a flight to {country} and then we stayed there for seven hours and then we took a flight to Edinburgh [] Yeah there were, we were three or four families	1 (26-27)
	Forming friendships	Making friends in school was very hard... firstly when I went to school, everyone was very nice to me but when they found out that I couldn't speak English or... yeah... they... tried to bully me as well... so that was very hard, but then after I learned English I made good friends with everyone	4 (95-98)
<i>Loss & Longing</i>	Learning public transport	I learned quite quickly... how to get the, how to get a bus, where everything was yeah	5 (132)
	I don't like the food	And the food.... I don't like the food (<i>laughter</i>) [] I don't like trying new foods yeah, [] it just doesn't have the taste it (<i>laughter</i>)	7 (182-186)
	I miss my family	Not really... like I've even forgotten who I was friends with, I just remember some, some things but, not very much [] But we still miss our families, we've still got family there yeah [] I miss... my family, my friends, yeah...	3 (53-54) 2 (35)
<i>Meeting Needs</i>	I just had to learn it	when we first came, we had to go straight to school and we didn't know any English, so it was a bit hard for us [] we kinda have, had to speak English so I learned quite fast, I learned in 6 months [] Yep there was no Arabic people or Kurdish people in my school so it was all English all the time so I just had to learn it [] and it was really hard at first because I couldn't understand anyone and I was just sitting there and the teacher was talking and I couldn't understand what he was saying.	3 (64-73)
	Allowances for English	They... when I came here first, I was meant to be in S2, but they put me a year down so I, cause I'm, because I couldn't speak any English so that was, I think that was very helpful	4 (84-85)
	Charities helped us	{Charity} helped us with a lot of, helped us with electricity and stuff at home, and how we can use them. How we can turn on and off the radiators and stuff. And {charity} took the adults for English lessons and the kids for playing in a separate hall and they also have a store for clothes, second hand clothes	8 (212-218)
	English support in school	When we first came there were Arabic translators that came into school twice a week to... into lessons with me to try and explain in Arabic or Kurdish... but after 6 months I learnt, they were coming in but I didn't need their help... so they just told the school that she doesn't need any help anymore so there's no point of us coming	4 (89-92)

	I used to cry everyday Bullying	yeah when, every single day, when I first came, when I went home from school, I used to cry, yeah, because I didn't have any friends and I didn't understand anything they were saying to me... and they were being annoying to me as well... They were just saying stuff to me, swearing at me, telling me to go away, telling me to go home, not sitting beside me in class, just because I couldn't speak English	9 (228-230) 9 (253-254)
	We need to help more	I think... trying to help like the students who come here like teach them more English in the first instance, go to school and see how they're doing, ask them if they're doing ok, if anyone is upsetting them or anything, yeah that would be good	11 (288-290)
<i>Identity</i>	Now I'm a normal person	Yeah I just go out like a normal English person because I can you know understand everything, I know where everything is, I ... made loads of friends, so yeah	10 (264-265)
	I got a scholarship	get a scholarship, so yeah [] they invited me to school for an interview and a tour, and the teacher told me I should take the entry exam, [] I passed it [] I was pretty proud of myself, yeah {Mum} She was, she was really happy about it	4 (103-112)

Young Person 4 (Waseem)

<u>Theme</u>	<u>Subtheme</u>	<u>Quote</u>	<u>Location: Page (lines)</u>
Loss/ Longing	Shock and suddenness of leaving home	we went to Lebanon just for one week, because my city its war, so they told us you have 48 minutes to go out because we were bombs the city (<i>tearful</i>) and we don't have car because my father he lost it and we can't go out and stay in home, the 48 minutes is done, is gone like. The war is started the homes, and we didn't know how to go out, we cannot run, we can't do anything, so my father has a friend he has a small car, 8 people was in the car just going out	3 (97-103)
	I see myself in them	Because I think,... other people you have to help them, yeah, and at home in Syria, I'm really sad when I saw that, videos, children are dying, I don't mind for the older people, because they saw his life or their life, but the children they saw nothing [] No life [] no, no blame [] Like me.....	7 (233-237)
	Death of grandfather	my and my grandfather died from the war, like someone kill him [] My my grandfather, he died he died he dead for ... 12 year no 10 years ago, no wait 9, 8 years, something like this	3 (78-81)
	I wanted to be a child	You know when I come here and I saw the... how can I tell you, the park where the children playing, you know I went there and I play, with the children because I have no other play when I was child	5 (146-147)
	We lost everything	so I was like 13 years old and my father was lawyer, yeah so he lost everything, home, cars, everything is like gone in the war and there is bomb so everything gone. And eh... So my father was lawyer, we went to Lebanon, he works like taxi [] like we were not rich but we had money, but when we lost everything, I was so sad, so every day when I am working, I cleaning everything, when I remember my father was lawyer and that, like say, so bad	1 (13-15) 7 (239-241)
	I wish I went to school	well yeah when I saw the children were out of the school and I can't go there (<i>tearful</i>), it was really sad and hard	1 (40-41)
	I was nervous and happy	So happy, yeah when I was in the airport I move around a lot, because everything is different so you know like the streets are different, people are different, everything so I feel like eh... how can I say it... nervous?	4 (133-135)
	Desperate to help family	(<i>Tearful</i>) everything... yeah everything, just to help my family to have money... yeah my father was so sad about it, because I didn't go to school but I never study or do anything, yeah [] anything I can work and just to help my family (<i>tearful</i>) so they give me <u>really low</u> money like anything money so yeah [] I was feeling so so so bad, like I have no friends and when I work I can't see my family cause 16 hours everyday, I have no off, like off day. I have like, for two months I have one day off.	1 (25-26) 2 (36-37) 4 (138-140) 5 (144-145)

		They don't care about it [] Yeah, when I have my money, I go just to my father and give him then I have no money. Family like to pay something for me for children and play but nothing.	
<i>Meeting Needs</i>	Teachers can't help us	But the teachers there, they can't help us because they have other students, you know, they can't stay with us, so nobody can... nobody can help us	6 (198-199)
	Trauma memories	I was going to school when I was 11, 10 years? So, I smelt ice cream and I just want to buy ice-cream and then go to school... and when I pay the ice cream, I just go walking into school and when I arrived to the door of the school I listened and boom like bomb you know the car, and I go round to my class and the teacher said that... the bomb was, they land on the ice cream. So you know if I late one minute I'm not here [] Yeah it was in {place name} if you search, you will see it	4 (107-111)
	No feelings towards bombs	nothing, nothing... because you know when you see the bomb every day, so you feel like it's, nothing (<i>claps</i>)	4 (117)
	It's good to talk about things	I don't want to tell anyone before but [] you want to talk about these things. It's nice to say I did but I didn't tell everything, I just tell you everything, I'm not sure why, yeah I had someone here ask me about to speak about my life but I spoke to him not everything, not like now	7 (228-229) 8 (246-249)
	Everyone feels the same	Of course, because... it's not just me I think, its everyone here you know [] Like some people they don't talk everything in here	8 (250)
	I don't speak to doctors	Oh doctors no I don't do them no, doctors no, never. I just when I have like a best, best friend so I just talk to him	8 (268-269)
<i>Identity</i>	Volunteering to help other young people	You know my English now is better, so I'm doing volunteering now- I'm teaching like a teacher in {primary school name}, yeah to speak English like the reading and the writing. I've been there for like 8 months [] Because normally, nobody can do that you know [] Yeah they don't speak English, yeah... they don't speak English, just Arabic... so just teaching them like... how to read []	5 (164-168) 6 (187)
	You have to help people	they have to do something for someone, like he doesn't speak English so you have to speak with him, they doesn't know anything like that	5 (162-163)
	Studying is important for future	Yeah, I just said, hi, how are you and so I just study every day in my home, just I want to do like a new life, I want to do study, I have to study cause that's the important things my life, yeah, I want to do that future you know?	2 (51-53)
	I don't just want money anymore, I want to study	You know what when I was child, I was just getting my money, I want to be a rich man, I want to be like that. Yeah when I come here, I feel really, really good because I go back to studying, I will have degree [] Yeah, no, no I don't want, I don't want to be rich, I want to do like degree and to do like some job, I can do that	3 (71-76)

Young Person 5 (Ahmed)

<u>Theme</u>	<u>Subtheme</u>	<u>Quote</u>	<u>Location: Page (lines)</u>
<i>Trust & Safety</i>	Experience of camps	I was in the camps and it was not nice [] lots of storms and ... yeah so it wasn't safe... lots of fire, I was far from my family and seeing my family and there is no access to anything, hard food to find	1 (17-19)
<i>Connection & Disconnect</i>	It's not the same	So... I felt sad.... I felt sad, so it was really far from family and my friends yeah [] we do speak to them yeah but it's not the same as... yeah different to to... like call them on the phone to see them	4 (116-117)
	Stayed inside initially	So... actually we stayed... in the house for like three months, we didn't, we didn't go out until... so you know the support worker came to our house yeah yeah for like to do appointments, so yeah	2 (44-46)
	Hard to communicate	It was hard for the like first year, yeah I... there wasn't so much people here, Kurdish people to know and our English was, was not that good... so it was hard for me... and my parents as well to <u>communicate</u> with other people	2 (42-44)
	I moved to lots of schools	so yeah it was hard for me because I moved to really like... lots of schools, yeah so I think, I can't remember, I changed about six schools, yeah like six schools [] Yeah just moving schools, yeah... and like some schools wasn't like too good for me	2 (50-52)
<i>Loss & Longing</i>	I didn't have any education	yeah and like from P3 to P6 I like, I didn't have any education, so like... well we did go to school but it wasn't.. a school, you know what I mean like... it was teaching but like... It's not... good as here. Like almost like tents, [] almost like tent schools and like really cold, and the school was like... you know the tent ... was like ripped and like just the cold, the cold wind just hit you and yeah that was during school, yeah that was... bad	2 (56-63)
	Positive memories of home	So {city} is a place where I miss, so because you know I've grown up there and there is... I miss my nursery, yeah my nursery... I still remember some like pictures, like my classroom sometimes, like I miss it, the sometimes pictures with my mums phone, like me in nursery, but this is like really nice... I miss.... And you know {city} is really... <u>was</u> beautiful [] Yeah it was beautiful, and yeah like in the spring... I know it's like desert but like is really nice weather and the plants	6 (205-211)
	Leaving family behind	So when we moved my grand, my grandmother was sick so (<i>sigh</i>) so... it was sad for us we didn't have time to see her, we just didn't see her.... So I <u>still</u> haven't seen my grandmother, well my family for seven years [] Yeah I haven't seen some of my family for like seven years. There is some family that... I don't know them and that's... quite hard you know, yeah	3 (108-114)
	I didn't get a childhood	You know you know P3 you do you know like the small people like to like play until P6 or P7, they still want to play, so like we didn't see much of that, so you know that's quite... so now you know	4 (123-127)

		we got to this age, we want to go out and to have a good life, but... and then you need to like study as well. The studying is like, can like stop us, not like, not like P3	
	My future is gone	so back there I said OK my future is gone, its hard you know, teenager... when I'm small, I am person who says (<i>sigh</i>) my future is gone, so you know I didn't see my childhood... so much,	4 (121-123)
	Shock of the weather/ differences	Soo it was a new thing so it was like totally different. So when I moved here... so I thought it will be warmer (<i>laughter</i>) yeah so I kind of, I just like... I stood at the door of the plane and then... it opened and the cold wind just in (<i>gesturing, bringing hands towards himself quickly</i>) ohhhh yeah, I was wearing shorts and, shorts and long sleeves, so I was really really cold (<i>laughter</i>)....	2 (38-41)
Meeting Needs	Problems with interpreters	The thing is... the hospitals, when my sisters, my mum doesn't speak English so it's really hard for her because of my sister, so then... When, when we say can you apply for an interpreter, so they say yes and then... but then when we go there is no interpreter... so I think that's the one that.... so because I'm not free and I... go to school you know and I and it's not my, it's not my thing to go [] Yeah she must go with her, you know it's hard for my mum to understand English	5 (185-190)
	New people need to know Edinburgh	Yeah, I guess like to help... because the new people come here, they need to know Edinburgh... because the first thing they came, they don't know what is. So they know their GP and the nearest supermarket so it was... so the first we arrived eh... there wasn't any, anyone to show us Edinburgh where the shop is and where is easy to buy stuff. That was quite difficult for us	3 (94-97)
	School tries to help but misguided	Chemistry is hard for a child like me because... I haven't studied physics, science things in over, back home so it's really hard for me to understand in Arabic, ... so sometimes my school translate like big words... so I doesn't know what it is in Arabic so... I've never seen it and I've never studied chemistry so I more like to understand, I understand English than like Arabic.	5 (151-156)
Identity	It will never be my home	So... my home is in {city}, so you know Iraq is not my home and eh... will never be my home.	6 (204)
	What will happen with Brexit?	they said Brexit (<i>sigh</i>) I don't know what Brexit is and so they told me in Modern Studies, so more time I see Brexit (<i>sigh</i>) I see you need to apply for visa so I said ah, that's not good, that's not good. We need so (<i>sigh</i>) yeah it's not stopping us to move really so Yeah that's quite annoying for me, [] to visit family, or to go work, or to go study (<i>shrugs</i>) [] Yeah takes away lots of opportunities	5 (172-176)
	More opportunities	The best thing about moving to Scotland.... It give us, it give us more opportunity to have a good future, you know, and... actually help me as well	4 (119-120)

Young Person 6 (Saad)

<u>Theme</u>	<u>Subtheme</u>	<u>Quote</u>	<u>Location: Page (lines)</u>
<i>Trust & Safety</i>	It's hard to get to the UK	It's hard is coming here, it's so hard... maybe is like... maybe we need like... My cousin just need come here, he speak to my Dad, my Dad he say like I don't know, it's so hard.	5 (171-173)
	Difficulty of asylum with criminal record	We need to get to this country. Like if you have a problems of the people, you can get out and you can to this countries and stay there. If doesn't have any problems, you can come here, at first time... quickly. Like if you have like problems like any hit him, hit anyone in their countries, then like it's so long for coming in UK, yeah long time.... If you don't you come in so quick	6 (189-192)
	Children accepted for asylum quickly	I'm coming so quick here like because I don't have any problems. They ask me like, what are you doing in Scotland, I say now you know I'm job, I'm still a job, I'm so tired for that, I'm younger now, like I'm younger like 14 years, they say like really quickly for that if you go to Scotland... yes of course they say you go maybe in one year?	6 (193-195)
	Fear of going back	I'm not back in Syria never, not after three years because all the, after... all the 18, which mean I'm like old of 18, 18 years, I can't back in Syria yeah [] Because take me in police and... yeah that's it	5 (151-154)
<i>Connection & Disconnect</i>	I'm not the same as these people	like you know when you do to any country different (<i>thumping hand on chair- interpreted as nervous/ agitated</i>) from you country, you say like tsk ah I'm not same these people... yeah I'm saying this...[] Yeah that is my feeling [] Maybe not... maybe still... but I think this is still	3 (100-105)
	Family likes only Arabic food	Like my family, they like food Arabic, they still like cooking for that. I say like do anything do anything for like food Scottish, they say I can't do it, I can't do that, only Arabic, only Arabic	5 (143-145)
<i>Loss & Longing</i>	Previous work as a child	I like I have job in Jordan, I start job in like... at 7 years old? [] I go with my Dad in like supermarkets, he has like a supermarket... and I go with my uncles..., then when I go to Jordan.. I go to job to café, yeah, I make tea, coffee, anything yeah.... And yeah that's it [] I job everything, <u>everything</u> yeah [] Yeah yeah, if you tell me to any, <u>any</u> job, I say I can... not hard for me	2 (65-74)
	Everything is so different	Different for... roads, cars, buildings, countries, people, speaking language, all of them like difference, yeah em... schools	2 (35-36)
	Missing my family	<u>Yeah</u> , same my family, my family is like my uncle and my aunt and... my grandfather... grandmother all they say sad like... not being like with me. I miss them like to like 10 years... I just seen them [] We've got many people like this, my cousin.... Yeah that's all... (<i>trails off</i>)	4 (109-114)
<i>Meeting Needs</i>	Teachers are	Like teachers, is so good for here. Yeah like teachers is there, like they hit you [] if you don't say	3 (89-96)

	good here	like do any homework like... maybe they say don't come into school again, it's very scary yeah... so I'm surprised like <u>very</u> surprised like teachers here. Like sometimes here, I'm not doing my homework, I'm scared, very scared for teacher (<i>laughter</i>) I say I'm not doing it, they say its fine, tomorrow you do it (<i>laughter</i> [] I like <u>wow</u> , no hitting... yeah that's it	
	I just sit in the class and don't understand	just, I went, I will be like in school, and just, they will, just like don't understand English like speaking, and just them sit in the class and I show what like studies, what they doing... and then next time, like next 6 month they has, I has like good language.	2 (43-45)
	Community support	like some families from Syria, in Syria, they speak in Arabic, they help me, help my family when you find food or ... wearing like eh (<i>gestures to clothes</i>)	4 (138-139)
	Scotland helped us	Scotland has helped me for... everything... like not just me, like all the people, same you, me, yeah not just the Syrian people... all that has lived here, you can like help them	6 (196-198)
	It's good to live here	Because... its good here for living, and good for people, no problems, yeah that's it, for a job or for school... and it's good for learning English, yeah that's it [] here is like... so easy to find job... and buses and cars, and like people here like still... smiling (<i>laughter</i>) yeah...	1 (15-16)
	Support worker helped my family	but she's like... everything like she's gathered it for my family yeah... my family like in school, where to go to school when you go talk, go talk to her or Any appointments Or talk to her or where pass was... or anything or ideas for here yeah... she's helped my family	4 (125-130)
Identity	Pride in speaking English	<u>But</u> is my language, is very good for <u>me</u> ... because I'm not studying in English before, yeah... like I'm coming here to Scotland, you know I don't have like... you know ABCD, I don't have that [] Yeah... I don't have <u>all</u> that, I can just like speak hello (<i>laughter</i>) and goodbye [] Like... I'm speaking to you now... before 6 months or... I can't speak these same things	2 (47-55)
	These are all my countries	And this is my country too, Jordan. Yeah I love very Jordan like... and is, that's it like yeah [] Yeah I say it is my country too... same thing in Scotland, this is all my countries	1 (30) 2 (79)
	People only need to focus	Yeah my friends say, they say like how can you do like, is very hard for you cause you not have language before... or have school before... I say its fine. I say like... everyone like is, is focused and will focus in like in this in this thing, yeah that's it	2 (57-60)
	Family wants the best for him	No, they say my family like, they say stay in, stay in Scotland. This is your life there, this is good country good people good job	5 (149-150)

Fareda (Mother) Case Analysis

<u>Theme</u>	<u>Sub- Theme</u>	<u>Quote</u>	<u>Location: Page (Line)</u>
<i>Trust & Safety</i>	I don't know what situation she is in	The reunion situation, I've got a daughter, an only daughter. She's in Aleppo- she's still there. She was in Lebanon also, but I don't know what the situation is like in Lebanon but they just told her (daughter) that you have to go back to Syria.	5; 171-173
<i>Connection & Disconnect</i>	You can't compare between countries	Everywhere you go there are some people good and some people bad, and even in family some people nice, some people not nice; you can't compare between two countries.	3; 75-76
	I feel bad	It is hard when I feel bad about having priority over neighbours that live here.	11; 371
<i>Loss/ Longing</i>	There is a lot different	I like the people. But there is a lot different between here and our country, weather, food, culture and the most important thing is family. That makes it very difficult	1; 44-45
	The important thing is family	And I can't, like, even by visa or something like this. We don't mind [] We don't mind to pay or something like this, the important thing that we want family to be close to us	6; 175-176
	I can't sleep thinking about her	I always think about my daughter, and sometimes I can't sleep thinking about her	6; 191
	Allah bless them	She (Mum) is in {city}, and {city} being bombed [] Allah bless them	6; 199
<i>Meeting Needs</i>	They don't laugh, they just help you	When I talk to them, if you have some mistake, they don't laugh. They just correct it for you, they just say, you have to say that [] the tutor told me, don't worry, that you will get it. Don't say that it is very difficult, it is not. And I am really happy for that	1; 49-51
	We say thank you	We say thank you to everybody in Scotland who helped	4; 104
	The council tax is high	And the council tax- it's too high [] I pay for TV also, gas, electric- I pay £91 [] only two people. For that reason it is a lot [] And I do not take a shower a lot, well not every day	5; 158-160
	I don't know where to bid	I'm waiting for council house as well [] Because I don't know the areas and I don't know where to bid because of racism as well. It's very difficult for me. I ask my support worker but she said I can't bid instead of you	11; 363-364
<i>Identity</i>	I like to learn	I am 68, but I like to learn English [] I don't have to go to English classes but I like to go	3; 84-86
	Everything is my responsibility	Everything is my responsibility. My son has operation, my husband has operation and it is a very difficult life, yeah and... if someone, who was like my daughter, could help her a lot	6; 182-183
	Islam no drinking	Islam no	8; 270

Raheef (Mother) Case Analysis

<u>Theme</u>	<u>Sub- Theme</u>	<u>Quote</u>	<u>Location: Page (Line)</u>
<i>Connection & Disconnect</i>	We know each other through community	Only from the community here	1; 26
	It's a big barrier between us	Also language- it's a big barrier between me and other people. When I go level by level, there are a lot of barriers, between level and level of English,	2; 38-39
	We followed my husband	Reunited [] Yes, my husband first arrived in Edinburgh and we reunited here, followed my husband	3; 96
<i>Needs</i>	All the neighbours run to help	If someone faint or feel that there is any problem, all the neighbours run to them and say What's going on? What's going on? And one day my son's head was injured and someone came and take him to the doctor and I was just running behind them, without slippers or anything and shouting, 'where is my son? Where is my son? <i>Laughter</i>	2; 69-72
<i>Identity</i>	She is Scottish	I had only one son at that time. And {daughter}, she is Scottish <i>laughter</i>	3; 98

Fatima (Mother) Case Analysis

<u>Theme</u>	<u>Sub- Theme</u>	<u>Quote</u>	<u>Location: Page (Line)</u>
<i>Connection & Disconnect</i>	Their teacher helps	My children, they have a teacher assistant to help them with English language at school. [] Their teacher is from Syria as well, from Damascus, yes, so she helps them	9; 299-300
	They don't understand	Happier here [] Because my children are small age, they don't understand	10; 309-310
	It doesn't taste of anything	Nice. Comfortable. But it doesn't taste of anything <i>laughter</i> . It is for example when you eat meat, this is an expression in our culture, when you eat meat without salt, it doesn't taste of anything <i>laughter</i> [] Comfortable but it's very difficult as well.	1; 29-31
<i>Loss & Longing</i>	It affects you	Yes of course, it affects yeah. Of course if you have your sisters, brothers round you	7; 226
<i>Meeting Needs</i>	It is very busy with lots of appointments	I have four children and a lot of appointments, school running all the time, very busy. It is very difficult	2; 35-36
	I have financial problems	Yeah, money is a big problem but some of them say no [] I've got financial problem, we have to cope with this all or else	3; 109-112
	So can you help me?	My family still in Syria. And my family in Lebanon [] I asked my support worker about my sister, because she wants to come here and study [] we've been told by the support worker that you have to go to the lawyer and ask the lawyer, so can you help me?	7; 207-209
	Provide us with permanent house	When we first arrive to Edinburgh, if you would provide us with a permanent house that would be better for all of us yeah.	12; 372-373

<u>Theme</u>	<u>Sub- Theme</u>	<u>Quote</u>	<u>Location: Page (Line)</u>
<i>Trust & Safety</i>	I don't know what the fear is	I don't know that they feel that they are afraid or scared because of Islamophobia. But I don't know exactly what the fear is. So for that reason, yeah, completely different life here	1; 56-59
	They think it will be difficult to return them	To the UK is very difficult, because she is refugee. The government here does not allow refugees to come here [] for visiting [] because they think it might be very difficult to eh, return them. And they would live like as refugee here, yeah so, but they wouldn't you know.	8; 238-240
<i>Connection & Disconnect</i>	It was very difficult for my son	When they first arrived, it was very difficult, the first three or four months, even year. And at the school and in the class, it was very difficult for him. Yes, when you first arrive to a new class and you can't really get others, it's very difficult. So and now they are very close friends	9; 286-290
	No change school	No change [] no change school, he wants to stay at the same school yeah	9; 293
	The teachers check on him	Even with my son, the teachers like him so much, and he is very happy here now. Even if they see some changes they say, "oh {name} are you OK? Are you fine?"	10; 303-304
	I feel that this is my home	Here people are very friendly, nice, kind with a smile. Also it does not feel that this is a new country because of the people here so I feel that this is my home	2; 46-47
	Here is completely different	People in Syria are very nice and friendly and there are doors always open. But here, no. Here you can't. For example in Syria you have neighbour, you will just knock on the door and go inside, have coffee, tea, food together. Here is completely different, you have to get an appointment or that	1; 50-56
	This was the last time knocking on doors	Yes, when we first arrived after three or four months, someone told me that my neighbour next door is sick, and she is not feeling well. I knocked on the door to just say hi, how are you, do you need any help? And she said no, you can't come in here, <i>gestures with hands in front of her, palms displayed</i> . And this was the last time knocking on the doors, <i>laughter</i>	2; 62-65
<i>Loss & Longing</i>	At last I said come illegally	I was telling her son, come just come, and at last I told him just come by illegal way or just smuggle, and he came by legal way <i>laughter</i>	6; 184-185
	They want to see each other	My son was twelve years so he missed his cousins, yeah for that reason, it was very difficult for him And because his cousins went to Norway. They want to come and see {name} and {name} wants to go there and so it has been difficult for both of them yeah	10; 314-315
	Contact with family	I am very happy that my family is contacting me	6; 19
<i>Meeting Needs</i>	I need a house	No just a nice house, I need a house	7; 357-358

Sabah (Mother) Case Analysis

<u>Theme</u>	<u>Sub- Theme</u>	<u>Quote</u>	<u>Location: Page (Line)</u>
<i>Trust & Safety</i>	The rules are so strict	The rules, you know, all the rules are so strict in the UK, yeah, so that's all of it	8; 242
<i>Connection & Disconnect</i>	I can't separate work and personal life	Some families, when I go and do the interpreting for them, sometimes I have to contact them from my phone. You know, they can save my number easily and I only got one mobile number so I don't separate numbers. One day, one of them, I don't save the numbers, yeah one day, just an unknown mobile number phone me at 11pm [] could you please help me?	10; 328-331
	Difficult to move to new house and start again	When you get your area and your neighbour, and everything around you, your house, your flat, yeah that makes it very difficult to move to the new house and start from the beginning and start again.	12; 374-377
	I stayed in my house for 3 months	Oh yes. It would have been very good to know you when I first arrived, you could help me. I stayed inside my house for 3 months when I first arrived and did not want to go outside. I told my husband that I did not want to stay here, I want to go back to Syria. Now it is better but I missed my family and my home. Now I miss Edinburgh when I go on holiday.	12; 385-388
<i>Loss & Longing</i>	We all have families we want to see	It is very difficult, yeah, it is very difficult because all of us got families. If someone has got their family, everyone wants, yeah, you know, you understand that.	6; 193-194
	God bless them	God bless them... *quiet*	7; 202
	I would like to go home	Yes when it is safe, I would like to go home	12; 390
	We can't forget about them	Yes, oh yes. Our communication is very strong, and for that reason, yes. We can't forget about them. Our culture is like this yes.	7; 228-229
<i>Meeting Needs</i>	They have all of this for families	So they help them, us a lot. And they get also, I don't know what it's called, they get to buy clothes when they first arrive, yes, and the flat furnished. And everything is clean, yeah they honestly they have all of this for Syrian families	4; 122-124
	Different ages	You know, children with different ages are very different	2; 313
<i>Identity</i>	Some Muslims drink	Some Muslims drink alcohol as well	9; 274

Service 1 Case Analysis

<u>Theme</u>	<u>Sub- Theme</u>	<u>Quote</u>	<u>Location: Page (Line)</u>
<i>Trust & Safety</i>	Not what indirect workers are expecting	That person became his confidante, completely understandably. And so that person was having to deal with the child's trauma [] that was really tricky because that wasn't what he'd bargained for [] And they have very limited support so there's concern there about what interpreters are left with	2; 37-40
	Placed in an unsafe community	the community that they'd were placed in, wasn't necessarily a very safe community, so the parents ongoing trauma reactions were kinda maintained by things happening in their stairwell or in their street	3; 76-79
	Court processes seem punitive	think there's something different as well about the court processes for somebody who has survived abuse for example in principle are set up to potentially be supportive whereas the processes around refugees/asylum seekers seem quite punitive and rejecting almost.	4; 113-115
	Belief about age	is belief about age as well [] and the Home Office often does checks and assessments around that so they're potentially not feeling believed [] if someone's been through all of that and they've worked since they were quite young and they've travelled independently, you think well yeah they probably do seem older because they've had that experience	4; 116-119
	How can they trust us?	How can they trust us lot because we're in a position of authority in their minds, which we are in a way. You could scupper their applications for whatever they're applying for	6; 162-163
	Home Office is at the forefront	Huge numbers of people we work with are waiting for their home office interview, and that becomes, [], that is the be all and end all and at the foremost of their minds. That's the thing causing them sleepless nights, they've got all this horrific trauma, but that's what's keeping them up, because that's what's, that's the be all and end all for the safety stuff	6; 164-168
	They've no idea where they are	Sometimes they've no idea what country they're in when they arrive here and they're not sure what countries they've been through. They've just arrived at Waverly station, handed themselves into the police sometimes, you know, things like that, no idea where they are	2; 66-68
<i>Connection & Disconnect</i>	Parents disconnected from their child	a bit of a disconnect about the parents seeing their anxiety and trauma symptoms really, had any bearing on their child's behaviour [] the parents trauma understandably prevents these children from mixing and being allowed to go out and play or anything because it's been so unsafe for them	6; 69-71
	How trauma is conceptualised in	A lot of physical health complaints so headaches, stomach aches, eating difficulties, sleep difficulties and [] nothing wrong with your teeth- its tension and stress. And yeah I was	1; 49-53

	other cultures	wondering whether, how trauma presents and how it's conceptualised in their culture.	
	It becomes disconnected from the translation	What is the direct translation for trauma [] you don't to be using a word that was you know invalidating and it was, [] 'damaged' [] will say something maybe accompanied by tears or laughter. But then by the time those words get to me, it's become disconnected from the actual expression of emotions	8; 232-238
	Connection with the refugee community	I don't have a strong connection with some of the communities that are out there [] there could maybe be a bit more joint-upness. You know what are the issues they bring to you, what advice could we give them or what training	16; 419-496
<i>Meeting Needs</i>	Everyone has been there for them	<u>Everyone</u> has been there for them, this is whether its school, college, social workers have been excellent and it really felt like we were part of something that you wanted to try and help with	17; 528-531
	They just need to feel safe	They just need to feel safe. You know they may not ever want to think about what's happened to them, or it might be years down the line. So I suppose it's about not assuming that everyone wants to process their trauma and immediately think that that would be something that they would do.	9; 256-259
	You don't realise there's anything wrong until later	your body has to readdress your arousal levels, because if you have been so used to living with something that is the norm and you don't realise that there's anything wrong [] sometimes don't even know what's so wrong about it until they move into a place where a lot of that stuff doesn't happen and they get what they need and then it becomes a traumatic experience because they realise how awful their home life was. And I do think there's this kind of thing where you need enough time to get used to something, to get to know something and to feel around it, and then maybe it hits you down the line as to maybe how bad it was [] But him being really depressed and sad that he didn't have that at all. So that's come later and not part of the direct trauma, but that's a latter response	12; 355-364
	Let people settle	We don't need to come rushing in waving a magic wand and do the trauma work with them. [] Its more about supporting people that are involved in the day, every day basis with them to begin with , to let them settle and then let them see what, there might be post	11; 320-322
<i>Identity</i>	Social media highlights their plight	There is something about the social media with it, highlights people plight in a way maybe that the general population maybe wasn't so aware of. So I think they're brought people in maybe being aware of [] maybe some of the awfulness that people of had on their journey	20; 596-599
	Difficult to be seen as vulnerable	the translator was part of their social group maybe or is in a power position [] that's really difficult then for them to be seen as vulnerable in front of this person who is trying to help them	7; 187-189

<i>Unknown & Uncertainty</i>	The measures we have aren't appropriate	Hypervigilance was almost numbed out because course he's not gonna be scared in Scotland because he had bombs in his country, so he's almost not scared of anything at all. But he probably still is really traumatised, so the measures that we have aren't particularly, you know [] actually he didn't really score that high	12; 350-354
	Talking therapies are culturally alien	some people just don't engage in our processes because they may be alien anyway sort of talking therapies culturally and they're having to come and meet people and use translators and things and that's a big undertaking	8; 251-254
	You can't do that with words	The therapeutic techniques like developing a safe space and that's been different and complicated [] a group of refugees who did art and kind of creative activities T[] this is a way of connecting your life story in a way that you can't do with words [] maybe therapy needs to be more creative [] also having the peer group that understands	12; 373-376
	Not knowing what the real story is	I was just thinking about, you know the young person's perspective of things and what they know might be different from what the accepted story is and then them not being able to talk about it	6; 159-161
	What is the norm in this culture?	think something that has come up for me is the norms like what would be normal in our culture [] some of what he says is taken in maybe a different context to what it would be taken in his own culture because of the norms that we have, in terms of risk	7; 192-194
	They'd never sat in a classroom	Some of these children as well, they'd never sat in a classroom before so you know suddenly we plonk them in a classroom and of course then they disrupt everybody because they get up and wander about you know, why not?	9; 275-278
	Getting used to that was huge	So there's all that thing about the whole difference of things and getting used to that was huge for us all to think about. And when you think about it it's obvious, but when you don't it's not. And until we knew the kinda things coming our way you know [] that's all new to us	9; 279-281
	How do I find out about the culture?	it's a bit about how do I find out about the culture sometimes, [] you would expected to be independent at this age and you know blah versus this culture where [] You know, some <u>really basic</u> things like that which could make or break the relationship	18; 547-549
<i>Vocational Discord</i>	Had to make the best of what we've got	but you know, time pressures, waiting list pressures, with all these things coming into play, there's not enough of us or them, of other agencies you know, and I think we've had to make the best of what we've got	17; 537-539
	Services then can't change	it means services cant then change, you know system wise, for individual [] the kind of system or service that we offer is probably not the best way of offering trauma work to this population [] without any one person sitting above housing education you know, there's no one kind of holding that and everyone just keeps going round doing our own little bits of it	10; 300-302

That anxiety from the key worker	But I think it was almost that anxiety from the key worker that they were wanting them to be ok and wanting to do the right thing when actually this was the best option to say, you need to talk about what's happened when actually [] he was doing really well, you know	10; 311-313
It hits the personal stuff	One of our colleagues came in and [] she was in bits and when you read the story and how awful it was [] it hits the personal stuff but sometimes it's just the enormity of the difference of what they've gone through is just, you know hard to take in	15; 444-447
Putting my own perception	I think when I heard this young person's story, I was thinking, Oh gosh, this young person's journey over here was so traumatic and I thought that that would be the focus [] I think I was perhaps putting my own perception of what he would have found traumatising	1; 54-60
We're slow learners	We're learning [] But I think we're very slow learners really <i>laughter</i> because refugees, no I mean systemically, because refugees have been coming for years and years and years	19; 582-583
Not had the same boundaries	they have a lot of rules and boundaries that are out round a 14 year old [] but they've just made their way across Europe [] and suddenly they're not allowed to be out beyond 9pm and there is that kind of juxtaposition [] actually they've not had those boundaries because they've had to survive, nobody's looked after them in that way	18; 564-574
It's difficult to empathise without experience	As a practitioner what they've been through because it's completely out with what our society deals with [] So really being able to truly empathise and also the other person knowing that we haven't experienced that as well	1; 23-24
I didn't want to scupper anything legal	I didn't want to scupper anything legal- I would do anything to just ease that awful process along to get those children settled [] they're the carers in this position, they travelled miles with these children you know	4; 131-137
What's important here?	We're now thrown into well what's important here? Unless there was someone at risk or, you know you follow those child protection things [] Practically the second thing you're every asked, after your name or your age [] it's quite mysterious for them to the fact that we're so caught up in ages and dates and whether you're in children's services or	5; 148-153

Service 2 Case Analysis

<u>Theme</u>	<u>Sub- Theme</u>	<u>Quote</u>	<u>Location: Page (Line)</u>
Trust & Safety	Can they stay?	This sense of can they stay is often absolutely incredible, and that temporariness of you are	5; 124-126

		allowed to stay but it's only for a set period of time and then it'll be reviewed. There's a real kind an injustice of some people get to stay and some people don't	
	They don't even know where they are	A real sense of they don't even know where they are, in terms of are they in Edinburgh? Are they in Glasgow? [] For some, is this London [] youngsters seem to be the ones that are mostly kinda picked up in odd, odd places, [] there was somebody recently who presented by knocking on the window of a pub [] he'd escaped from a cannabis farm wasn't it?	1; 14-17
	Trying to catch up with physical health	Clinics have caught up [] so there's a lot more systems in place, making sure that peoples physical health is better managed. But there's a lot of kinda unusual illnesses coming that aren't necessarily prevalent here [] potentially TB, potentially hepatitis, in an acute phase	4; 53-56
	Making space for staff who have previous experience	making space for people who have had experiences from, to help communicate together so [] to help them just manage those conversations and not assume that all kids will be the same [] or to share ideas where you can get these resources in the library or just really practical things [] there's a bit more of a sense that people are a bit more prepared and are learning from their mistakes [] actually there's a lot more thought and planning	4; 90-100
	On their own in an alien culture	these are young people who are completely on their own in an alien culture so not having any points of familiarity has a much more significant impact, and I don't think that that can be underestimated, and then there's, there are all sorts of other things that come in on top of that	5; 105-110
	Fear of what they've left behind	Often they carry with them, a real objective anxiety about what they've behind and who they've left behind and sometimes they can't communicate so their emotional fantasy of what's happened to their mum or whatever.	5; 115-119
	They're set up to have distrust	I suppose the complexity of the legalities of it all are having an impact too. Because actually for that youngster em, if they're not believed, then that's a really horrible position to be living in that actually people don't believe you are who you say you are so how can you get any concept of trust if people fundamentally don't believe you	18; 452-458
	Staff concerns about who is visiting	when you do meet people from the community, the conversations are, in a language the staff don't understand [] who's visiting, what they were like and whatever [] Are they being bullied, are they being exploited or are they just chatting about the TV	2; 33-36
	You have to tell the story to allow you to stay	people having to tell the story that allows them to stay, which at times muddles up their actual story because they've been given advice about what you need to say to stay, but then their own story might be just as bad and just as painful and just as awful but actually how do they how do they work out the truths for themselves	5; 129-132
	If you don't conform,	There's a need to conform isn't there? Because if you're not conforming you're not gonna	15; 357-360

	you don't get to stay	get to stay, so [] there's a need to conform and some of them manage that better than others, [] but I would say the majority of youngsters realise that actually they're not doing themselves any good if they don't play by the rules	
<i>Connection & Disconnect</i>	Familiar thing that anchors them	questions about diet and food and how diverse some of those things are, [] and food seems to represent something that is the familiar thing that really anchors them	1; 19-21
	Putting in adolescent boundaries	if someone has come over on a journey and that's been really dangerous and really difficult, then going to a unit where everything is kind of specified and what time lights off are	8; 183-185
	Too difficult for youngsters to fit	culturally for youngsters it kinda too difficult to live in a family where it had kinda, a very Christian Western brain, kinda backbone to it [] we've got a certain kinda style of parenting which actually is too, too difficult for youngsters to come into, to fit into	12; 291-295
<i>Meeting Needs</i>	Make them feel safe first	there was a real kinda feel from other agencies[] that we should start trauma work that we should be absolutely, completely kinda engaging them about their horrific experiences [] just to say to the residential staff, you're doing that work, to make them feel safe here, they've got all these symptoms but they've just arrived	13; 322-325
	Never to talk about that stuff	that a lot of young people have developed coping strategies for how to deal with their experiences and for some of those young people it's never to go there, never to talk about that stuff so there is quite a theme yeah with staff being really concerned about a young person's challenging behaviour [] but at the same time if they're trying to explore a referral [] for example to address that trauma, that the young person's not willing to go there	15; 381-384
<i>Identity</i>	Who am I and where do I belong?	The normal teenage processes of who am I and where do I belong and how much do I conform to my parents expectations and how much do I rebel against my culture and actually all that becomes more complicated if you've got that extra layer of information, misinformation, language barrier, lack of trust just you know gets in the way of working through some of that stuff	6; 150-154
	Possessions show I am valued	Some expectation [] and needing to have certain possessions, almost like symbolically showing that they're being valued. [] its almost about that they're being seen as a person, that these things take on a huge symbolic significance for them [] they've build up a picture of what this world is like	7; 158-161
	Projection of vulnerability	Whether you then project something onto them that they're really vulnerable or they're gonna rescue them, and whatever your own kinda fantasies are about	11; 262-263
	Different narratives on resettlement has different effects	if you've had trauma prenatally postnatally and kinda developmentally all the way through then that's different to somebody who has had that stable [] positive early years experience and their parents actually wanting to give them the best in life [] That's a very different	16-394-400

		experience and has very different effects on you and you may have experienced trauma on your journey but your starting point was different	
<i>Unknown & Uncertainty</i>	What must that feel like?	and I mean we can't grasp what that must feel like and having no point of reference for that	5; 123-124
	A real sense of the unknown	I suppose there's all the cultural differences actually and a real sense of a, of the unknown. Em, so people are kinda trying to deal with what's in front of them but don't really know, don't actually know the background of young people	1; 10-12
	There's a vacuum of information	Normally carers experience there a whole sense of the child they're looking after [] these carers have none of that but they're having to, that's the vacuum, there are things that might be said, that might be right or true or shaped differently. There's really no sense of a journey, really physical or tangible	10; 256-258
<i>Vocational Discord</i>	It was all kinda ad hoc	there was an informality that was allowed to happen and so people ended up in allowed to become carers without the proper assessments [] it was all ad hoc and informal [] people had come through back doors almost into their care and [] those placements didn't succeed	11; 277-280
	Trying to adapt to fit everyone's needs	In terms of google translate and phones. For some of the units youngsters weren't allowed phones in their rooms kinda overnight and things but actually, em, for someone that doesn't speak English, you need to be able to communicate [] you can't have one rule for one youngster and not for another. So actually its caused cultural changes within the units to try and adapt to how they fit everybody's different needs in complex way	1; 49-54
	Hard to do that ordinary checking in	because trust is such a big thing and you need to be believed by the home office and so trust is really important, then it's hard for residential staff to do the ordinary checking in that you would do with an adolescent, [] Have you been kinda where you said you were? [] people get caught in that no-man's land about what to do with [] ordinary adolescent development [] how does that feel for those people who are supposed to care for that youngster if they're not even allowed to have the permission to say, there's just something wrong. So they're all set up to have a real feeling of kinda distrust and not being genuine about it	8; 188-194
	Wanting to give a sense of other views	wanted to give a young girl a sense that actually she can have a voice and that it was ok to argue with men and actually how culturally different it is over here and that, I suppose depending on where that young girl wants to see herself in the future, it's how she can hold both of those views really because in the world there a is a place for both of those views [] So how are we not saying that our particular world view is the only view	10; 242-248
	Everyone wanted to be involved	it was a kinda sense of everyone wanted to be involved, to be offering something, to be seen to be offering something and sort of almost like, because it gave them some sort of	12; 300-302

	status and that sort of piecemeal approach has settled down more now	
Vast polarisation in different approaches	there's all this overcompensation to nurture, where nurture might actually need to take a different form [] in one such meeting [] the unit staff had seemed to get a bit more of a realistic kinda way of managing or thinking to be a little bit clearer with boundaries [] teachers were very much in this sorta idealised mould of they just need so much and you just have to love them so much [] it was a very difficult meeting because of this vast polarisation, their very two different approaches [] of course its somewhere in the middle	12; 305-311
Everything is in Glasgow	there is a concern that everything is in Glasgow in terms of Home Office, specialist resources everything's in Glasgow so these youngsters find their life's going back and forward to Glasgow [] how do they settle here because actually Glasgow is where all the power is	17; 430-433
Sentence somebody to be an adult	We question that are we actually potentially sending somebody somewhere, because none of us have any knowledge about this, it's really scary, that actually if you sentence somebody to be an adult then that's really scary [] that's conversations people have all the time [] and I suppose if you ask those questions then you have to answer	18; 461-463
There's something particular about this city	Empirical evidence from lots of different bits of the country but there's something about <u>this</u> city and what we've got <u>here</u> and what has been learned <u>here</u> in this particular culture of this city. There's another city in Scotland that has quite a <u>different</u> culture and its being done differently, and so there's something very much about recognising the culture of this city because it's not been able to, because its linked with Glasgow	20; 503-508
Not as linked to services as we could be	we are not probably as linked in with [] team as we should be [] although I think peoples expertise is increasing [] there doesn't feel like there's been a kinda strategic move [] it kinda still feels very ad hoc and it's the ground level experience that has kinda changed things kinda than actually a kind of making a strategic one	21; 539-542
Lack of power, money and resources	So those links are missing aren't they, so that's what needs to happen, so there's council but there's government [] and without that comes a lack of power and money and resources and [] Not surprising that there's a policy statement without funding or monitoring	23; 583-586

Service 3 Case Analysis

<u>Theme</u>	<u>Sub- Theme</u>	<u>Quote</u>	<u>Location:</u> <u>Page (Line)</u>
<i>Trust & Safety</i>	A lot more pressure for	they are granted status for 5 years which then, they are then able to apply for ILR, indefinite	2; 53-59

	citizenship	leave to remain and then they have one year to apply for citizenship after that so in terms of the difference, there's a lot more pressure, because to go through those pathways to citizenship, there's also a huge financial cost which they will have to meet, so given the, all of the loss and trauma that they've been through, to then come up with thousands	
	Relationships on a sound footing	it's been a slower kinda process eh of engaging and making sure that relationships are on a sound footing and us not launching into the trauma but being open to [] children talking about that when they are ready to do so, based on the relationship that you've built up over time. So not expecting a child to be able to want to but being open to that if they need to	4; 104-106
<i>Connection & Disconnect</i>	The effect of multiple moves on families	in a deeper way, you know the effect that multiple moves would have on families who are the most... vulnerable of vulnerable, who've <u>already</u> had, you know who have come here because of displacement you know I think that was very short sighted.	8; 222-225
	Importance of long term support	we recognise the importance of the long term therapeutic relationship, especially with this service user group because as every possibly you know, at every age and stage of development there will be other requirements for support given the pressures on the children in terms of processing the trauma	1; 27-31
	Our kids wouldn't come without transport	so we've put transport on to ensure that the children can get to the services whereas if transport wasn't provided, I would say 50% of our kids wouldn't come, perhaps more	5; 161-162
	Seeing people as part of relationship	it's a relationship based approach [] it's based on seeing people as <u>subjects</u> [] of a relationship rather than objects of an intervention	5; 133-136
	Food and hospitality are very important culturally	they say that you should treat your guests as if they're the Prophet Mohammed and therefore hospitality is key, is a big part of that and <u>feeding</u> your guest for however long they want to stay, so you know I think you know that's, that would be a big part of it [] And eating together, eating from the same plate is really.. pertinent in Syrian cultures [] The food is, the food is very important within our group work in children, the food that we provide	7; 192-195
	Sharing food and culture reciprocally	Mums group I mean cooking food, and eating food together and <u>being</u> together with food, you know that's about caring what they've brought from other places and sharing that here, it's being in a relationship in a reciprocal way as opposed to a domineering way	7; 206-209
<i>Meeting Needs</i>	They're moving to another temporary house	they've been in temporary accommodation for 4 years [] they're moving to another area of the city to <u>another</u> temporary house which I'm very cross about so the city council are moving them into, not their permanent house but into another temporary house, so I'd question well, so why have you done that? [] they've roots in this area [] not sure they'll be part of the group here anymore [] I think that the short term strategies of placing them in temporary accommodation when we consider the losses that they've been through	3; 90-95

	Quality of education is potluck	Education across the city, its ... potluck in a way [] Some schools are fantastic and very intuitive to the needs of the children and and and make adjustments, others struggle? To put themselves, probably understandably in some ways into the shoes of what the children have experienced and to see kinda some of their behaviours in that context and partly	9; 279-282
	Sat at home in your head all day	you're sat at home in your head all day, then what is the point in developing mental health services when you know that's a huge <u>strain</u> on someone's identity and sense of self.	8; 233-235
	Impacts of being a cultural broker	in terms of pressures that they are under as young translators [] Cultural brokers, which is children whose English is much in advance of their parents so them doing the interpreting and accompanying to GP appointments, and mediating between the outside world and their parents [] longitudinal studies the impact that has on the children's mental health so the damage will.. come out at a later date	4; 120-125
	It's about being a bridge between both sides	it's almost like being a bridge between family and school and helping to mediate that and hoping to, both sides to kind of understand where the other is coming from [] assisting the child or the family to present their views [] you have to be both sides	10; 290-291
	Parental trauma can cause difficulties with engaging children	<u>parental trauma</u> , so we've worked with a number of families [] whose trauma presentation has not been em... who have not been <u>supported</u> here who have then after a certain amount of time, for a complexity of reasons kind of withdrawn from services [] if the parents aren't giving consent then the children will be withdrawn	5; 144-149
<i>Identity</i>	Sense of self affected by school	how much the children have missed schooling, how behind they are in terms of everything, [] they might have ambitions to achieve or to do things but they've been held back by that and they're not understanding lessons and [] that then impacts, [] their sense of self, that they're seen as being stupid, or that they're not able to do or manage the work and not understanding what's being talked about in class and then feeling embarrassed [] And ashamed, feeling a big sense of shame	15; 439-444
	Lost their identity as breadwinner of the family	For many of the men who've come here have faced the biggest challenges in terms of the fact that they've lost their identity as the breadwinner of the family. Some of the men were engineers or professionals or blacksmiths or architects	8; 228-230
	Dependent cultures versus independent cultures	Children [] who are coming from very dependent cultures as opposed to <u>independent</u> cultures, [] getting Mums to realise they have that sense of self and <u>agency</u> and with <u>children</u> who are brought up in interdependent cultures	12; 350-354
<i>Unknown & Uncertainty</i>	A consultative model might be helpful	if there were people available to act as consultants, so that you have a consultative model so that if you can't bring the service to the child, then you bring the service to the agency or the workers who <u>can</u> bring the service to the child and provide them with some support	12; 361-363

	Take a present based approach	that's what most people are saying, take a present based approach, don't launch into the work you know to talk about the traumas that they've witnessed and I think whilst talking that present based approach, I sense the need for that long term therapeutic support	3; 87-89
	Keep it simple, not clinical	He just made it very simple and made it kind of an informal group meeting. So strip away any kinds auspices of clinical feeling, I think that's really important because that em... in the Syria community will put up defences, em... because the Syrian community is suspicious of psychiatric services, because just, the model is not there	14; 418-421
	Government have not made it clear	the stress has come from the fact that you know Scottish Government have not made it clear what is going to happen, I think the response has been well that will, that's an issue that's dealt with in Westminster, that's outwit our control, so that, the unknown is creating anxiety you know and that's very difficult and I think with families coming here who are seeking asylum	3; 61-65
	Western approach won't work	that's not terrain you would think of as classical you know Western style therapy which, you know I think, you know that approach just wouldn't work from, for the children coming here	13; 376-378
	CAMHS as a faceless organisation	we have very little dealings with CAMHS, to me there a bit of a mystery, bit of a faceless organisation, I don't <u>know</u> anybody who works in CAMHS, I've never had any <u>contact</u> ,	13; 386-389
	We've been proactive with involvement	we've been kind of reasonably proactive in terms of our involvement so that some of the barriers might not be the barriers that other agencies would be involved in, so maybe just trying to change how we offer services and the way that you offer them	6; 158-161
	This was not thought through	It was not thought through, and I think that it should have been thought through. I know that the scheme was set up as an immediate response to keep people safe, but I think that keeping people safe, should have been looked at with a longer term vision. Whilst we're dealing with crisis [] you also have to look at long term hopes dreams and aspirations	8; 236-240
	The response was too little too late	that still hasn't happened and you know I recognise the barriers [], that is difficult, but I still think that more could have been done, and I know speaking to Scottish government, the response was too little too late, I felt []there's still no answers	8; 245-247
Vocational Discord	I worry about their future	I worry about their future, these kids. They're struggling with education, with integration, what does that mean in terms of their livelihood [] will they just grow up to be another generation of angry young men who have no sense of their worth or opportunities.	15; 454-458
	I feel shame and embarrassment, it's not good enough	<u>personally</u> I feel a sense of shame and embarrassment about the employment situation for the men... and professionally... but that's like (<i>sigh</i>) you know taking my profession out of it, I just think it's... it's not good enough	9; 264-267
	It needs to come from the	that needs to come from government, we're a small NGO down here (<i>laughter</i>) we can't,	9; 262-263

government	you know we don't have the capacity to set stuff up in terms of employment	
Multiple barriers to mental health services	Due to the level of trauma, that intake interview has retraumatised them and then they are essentially left in an acute state of crisis slash acute relapse onto PTSD until they go back in... There is the issue of interpreters who may or may not be from the community, and then there is the barrier of the mistrust of psychiatric services, because they are not well-developed in Syria.	11; 327-331
Expectations on families to fit Western model	The expectation, again is [] of a centralised service, that a child is taken to a location? And that the family have to do that [] I don't think that's gonna work, [] Again it's that flexibility and adjusting so that so that, the service comes to the child	12; 339-341
There has to be a change of culture	think they would have to want it, they would have to want to reach out rather than expecting people to refer in and that they're the specialists [] There would have to be a change of culture about actually wanting to reach, [] CAMHS have never initiated any communication with this agency, so they're would have to be something more proactive	14; 401-407
Being more fluid with boundaries	if you came in with a very boundaried, statutory way of working then you've got to be more flexible, and that might mean going into the house, accepting offers of food [] almost being seen, although you <u>know</u> you're not a family friend, but being <u>seen</u> as a family friend and that's the way to engage so it's not saying there <u>isn't</u> a professional boundary, we're aware of it, but it's a looser, more fluid boundary and being comfortable with that	6; 168-173
Lack of communication between services	The statutory team hadn't informed them [] if I hadn't done that, there would have been no, there would have been, the the head teacher here wouldn't have been able to... organise goodbyes and endings... and so forth, due to that lack of communication	10; 303-305

Lauren (Carer) Case Analysis

<u>Theme</u>	<u>Sub- Theme</u>	<u>Quote</u>	<u>Location: Page (Line)</u>
Trust & Safety	His life was at risk	his father was a political figure and he was caught up in that and was murdered and X himself had been beaten up and he sort of had to leave because you know em his life was you know at risk,	5; 104-106
	His legs are covered in scars	a 16 year old who has then subsequently been across the <u>world</u> to get to here, having to try and remember what happened two years ago or a year and a half ago in in Africa [] I remember one time	14; 333-340

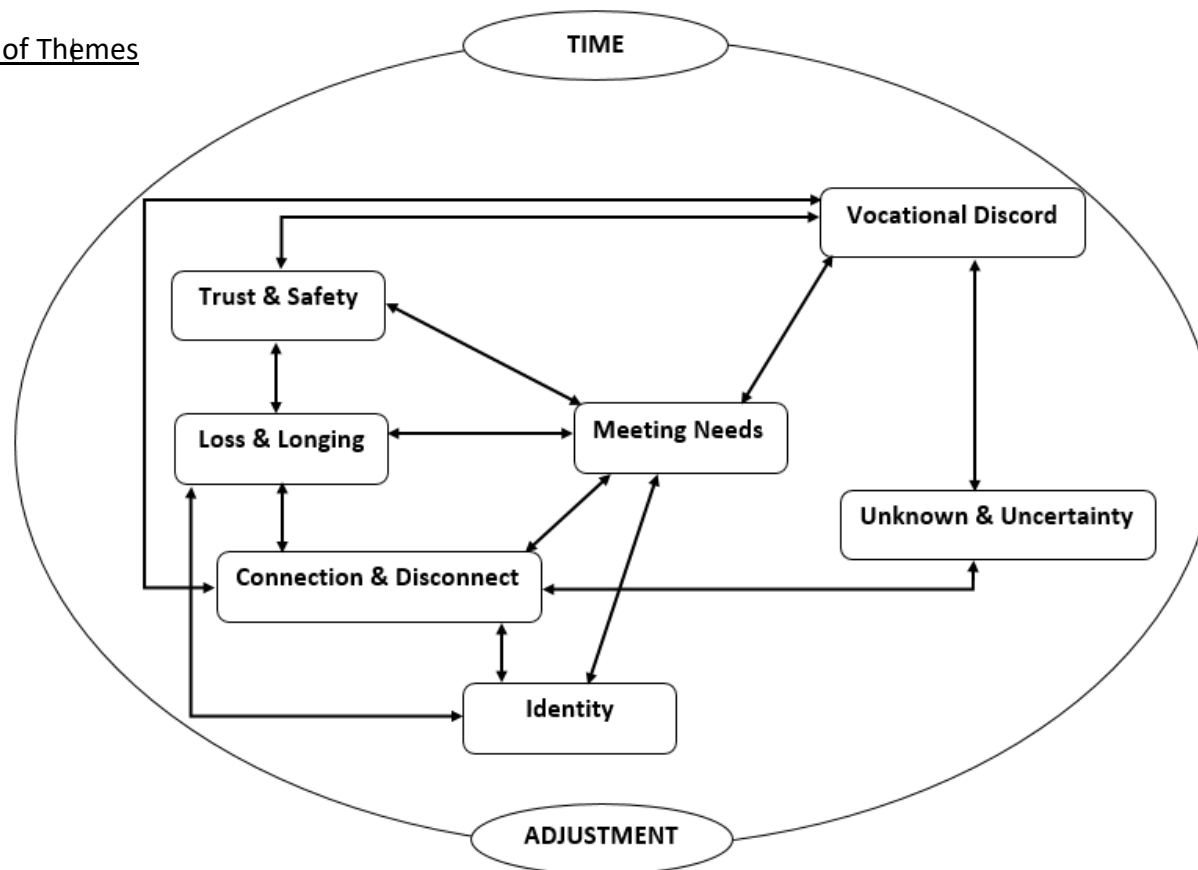
		of her saying 'but you said last time that they hit you on the <u>back</u> of the leg and now you're saying the <u>front</u> ' and I'm like <u>really</u> ? Look at his legs, his legs are covered in scars so... it was probably the back and the front from what I can see	
	They don't want to take ownership of them	the journey over was <u>horrendous</u> , the boat went down, he was rescued by the Italian coast guard, several people <u>weren't</u> , that people were in the water <u>dead</u> around them, em and then he he they were left on a beach initially because that's what the coastguard <u>do</u> , they just put them on a beach because otherwise they have to process them and they have to take ownership of them, claim them,	19; 451-454
Connection & Disconnect	I tried to cook food from home	I looked up recipes and menus and whatever and sort of checked with him that he recognised some of these things that'd I'd found and he did so then I ordered in spices, so we had to order a particular spice, Berbere, which is a particular Ethiopian spice that we got from Addis Ababa and the got on with the business then of having to (<i>laughter</i>) cook for him.	3; 56-60
	You had to just go with it until he could explain	he was terrified when he came to live with us and I think it was the intimacy of a white Scottish family, [] it took him a while to articulate, but he's painfully shy, so there were times initially when you could have thought, you could have interpreted the behaviour as rude as dismissive as insolent, and you just had to kind of go with that until he could find the language to articulate what it was	9; 217-220
	We gave him loads of space	When I look back now his photographs of him looking <u>terrified</u> at the beginning, I see <u>why</u> and then only four months later, there's this photograph of him inside Emirates with the gear on and <u>just</u> looking at that photograph. So he was probably terrified but relaxed pretty quickly. And you know we gave him <u>loads of space</u> you know he used to spend a lot of time in his room initially	11; 259-262
	Always travelling in groups	interestingly, cause I would say, gosh it must have been really lonely at times and he said no, it was <u>never</u> lonely because you were always travelling in groups, you were never alone, you were always in a group to get there there was always a, someone, different formations of groups together,	20; 473-475
Loss & Longing	He was following news items	know he was following <u>news</u> items about the political situation and the unrest or whatever and so he would <u>tell</u> me when, you know he would say 'oh things have kicked off again, and there's more protests and he would show me a little video about the unrest and he would recognise places or whatever from that em, so <u>he</u> was keeping on top of what was going on politically	18; 429-432
	Talking to Mum four years later	us all sitting there watching when he gets through to his mum (<i>tearful</i>) and then... thirty minutes of him holding back tears and we could hear him telling her about the journey he'd made, and then looking up every now and then to say that his mum was thanking us for his bed and thanking us for his education (<i>laughter</i>) and stuff and <u>us</u> trying to hold it together when it was really you know... making conversation four years down the line with his Mum	32; 799-784
Meeting Needs	Sees me as someone who can fix everything	I used to even wonder does he <u>know</u> , Does he even <u>understand</u> what kind of arrangement we have here or, I don't know whether he understood who we were and <u>how</u> he came to live with us [] I think he does see me as someone who can fix everything, you know he'll <u>call</u> me with you know, 'one of my friends is really struggling getting insurances dedededuh, so can you do it?' you know he just random stuff like that you know where he thinks yeah oh I know the woman who can sort that for ye	13; 315-323

	He has compartmentalised his whole life	<u>actually</u> I think part of why he has just managed to progress and develop so well is because he has compartmentalised his <u>whole</u> life, so there was (<i>using hands to indicate difference boxes lying on the table</i>) life in Ethiopia, there was life on the road, and then there was life in Scotland and they're so <u>unbelievably</u> interconnected yet... and so the only way to actually make sense of it is to keep them in these compartments and that <u>works</u> for him and I suspect that is how <u>all</u> of these lads have survived so well and do survive so well, that <u>awful things</u> have happened at home before they left, I have no <u>doubt</u> that awful things happened to them on the way	16; 389-399
	There just wasn't the expertise amongst locals	So that was the first letter was wrong... and you know the Home Office is a shambles, that whole experience was awful, so and the solicitors were useless, until we found a very good one eventually, but em there there there <u>wasn't</u> the expertise among local, as to be able to do that effectively, so we got some <u>really</u> shoddy experiences with solicitors and all the rest of it. Do you know, there's one organisation that does some really good stuff in Glasgow, just rang them and they have the have the have the expertise in working, in this sort of work so they were able to kinda guide and advise me	21; 516-521
Identity	He's absolutely clear on his choices	I mean quite although quite shy and all of these other things, absolutely stubborn and <u>absolutely</u> clear on his choices you know, so <u>fair enough</u> and you know just because I'm a fast Ethiopian runner doesn't mean I'm, you know gonna be one (<i>laughter</i>)	13; 301-305
	Becoming more Westernised by the day	But equally he is becoming more Westernised by the by the <u>day</u> ! You know he's embracing everything you know that he has you know here too, and he likes the notions of Ferraris and Lamborghinis and stuff like that, and we have a good laugh because him, as I said, him and my son have bought this little run around between them and they're having to afford it and insure it and all the rest of it and em you know he'll talk about, you know that's a that's a shit car and (<i>laughter</i>). You know and it's quite funny you know, I don't know I mean, his dad never owned a car, and they've never owned a car and (<i>laughter</i>) you know and he's, that's a shit car he has this relative to what he really would like.	35; 863-869
	Need to be wary about imposing narratives on young people	I think we need to be <u>really</u> careful with these lads... that we do not <u>impose</u> Western <u>notions</u> of trauma and ill health because that would be a <u>mistake</u> . We need to continue to play to their strengths, yes have an open mind for what might come, and it might and I'm ready for that when it does, but equally... for now... work with what what's in front of us, which is just the most incredible resilience, the most incredible strength and em.. positivity. [] I think some of our immigration systems doesn't recognise is that we've got the cream of the crop, we've got kids here who are physically fit, probably mentally well, strong, cognitively intelligent and actually bright so... these are the kids who've made it through horrendous sets of circumstances	38; 940-950
Unknown & Uncertainty	He was truly feet under the table by official assessment	he'd moved in and that was after I think we'd met him just twice maybe- once we'd come to see him, and once we'd then taken him out to meet our own family, have a wander round Edinburgh, take him down to see our house and the poor soul just looked <u>terrified</u> at the prospect of all this [] So from meeting him, just between Christmas and New Year, he was started school I think it was by the beginning of that term [] And then we had to go through some sort of process of approval to be	2; 32-38

		carers but he was already well and truly feet under the table by that stage	
	Having to rethink all our preconceptions	just so many cultural aspects for us, you know first of all having to learn our own preconceptions about Ethiopia and you know your thinking as a young person as a child and you know through to the 80s and 90s and BandAid and all the rest of it, was just all about famine and starvation in Ethiopia and so that is your mindset about Ethiopia.	4; 95-101
	Just so much to learn	there was so much to learn, so we had to learn about Ethiopia, the political system, we had to learn so much about Islam because I I didn't know very much about Islam at all and so early doors we, I, you know when it came for example to his first, Ramadan, I did, eh I went to the mosque... with him, just because I needed to get my head round it	5; 106-110
	So important to go at the child's pace	actually it was <u>right</u> not to push him into to that [] I think forcing that would have kind of just potentially broken everything down so it was right to go at <u>his</u> pace,.. That's more than anything else I've learnt, I've learnt that's it is <u>so important</u> to <u>go</u> at the child's pace so let them dictate the ... you know that those initial sorta stages so mhhm... what else woulda been terrifying for him	22; 262-265
	I would have to choke back tears	I was <u>I</u> would find that really upsetting, <u>I</u> would have to choke back tears watching <u>him</u> choking back tears in some of these meetings that we had to had to have em, so sorry that was another bit of the process, em cause there's so many different different, there's so many different parts to it all and <u>I</u> forget cause its three years ago all of the different bits that where em.. so him making sense of all, I mean how on earth do you, does he make sense of that Home Office process or <u>social work</u> processes	15; 348-353
	The experience wasn't there initially	just get yourself more knowledge about them, what the kids are coming from and you know in terms of their own backgrounds but also their journey and actually... give them space and so... I do think that that the knowledge, and experience and skill wasn't there initially I would say. Now one would hope that this far down the road, things have shifted a bit because there's subsequently far more children that have come in, from different cultures,	22; 537-542
<i>Vocational Discord</i>	She put unrealistic barriers in	a very traditional carer who who is a lovely carer who has cared for years for people [] it was a combination of him being a quirky lad, and her not really being trained or upskilled to know how to work with him, so her treating him like she would have treated a 14 year old Scottish child, and eh, putting in these perimeters around his movements which were unrealistic given what he'd just gone through. [] that led ultimately to that placement breaking down	23; 558-561
		but I was torn about that because I have all my other relationships over at this other school and maybe we should send him there and actually I was <u>really</u> glad we didn't because I don't think he woulda got quite the deal that he got across the road at {school name}.	29; 708-710
	You feel sick knowing that its normal for a child to go missing	I was saying, oh my God, I just can't imagine, <u>what</u> that is like for your mother, on a Saturday four years down the line having a conversation with her son... and he says but that would be So different for you than it is for my mum, that is just so the norm in Africa, that actually it's not like if {sons name} would just disappear tomorrow and it'd be a huge issue for <u>you</u> and the family and the extended family and community because it doesn't happen. That happens all the time in Africa, so	33; 794- 801

	people are used to it and a bit of you feels sick that actually that that is the case and thankful that it's not the case for you but that was just another insight into how different our worlds are	
How do we revisit our Western concepts?	one of the things is a challenge for just as a social worker, just everything we've ever thought about attachment and resilience and trauma and just how Westernised all of those concepts are when you realise just what his history has been em... you know and how do we actually how do we revisit these these our notions of trauma [] I do sometimes worry? that we... over medicalise <u>so</u> much of what is just growing up and normal experiences for our young people and actually I think maybe we need to talk a little less about some of this and focus on... <u>wellbeing</u> [] Just you know I just do worry that we we focus <u>too</u> much on the <u>self</u> and the individual and actually <u>not</u> on people as part of families, communities, societies	37; 905-916

Appendix N: Interaction of Themes



All themes were interconnected and were influenced by each other. Additionally, all themes traversed time, where the past influenced participants' present thoughts and feelings, subsequently impacting decision-making in the future. *Meeting Needs* appeared central to all participant groups, whether that was unmet needs from R/AS families or attempts to meet these needs by staff members. Unmet needs derived from difficulties with *Trust & Safety*, *Loss & Longing* and *Connection & Disconnect*, which also impact each other e.g. trust is needed in relationships in order for both parties to feel connected to each other. For staff participants, *Unknown & Uncertainty* affects how organisations provide support for R/AS families (*Vocational Discord*). Both themes (*Unknown & Uncertainty*, *Vocational Discord*) then impact the effectiveness of organisations to meet needs. *Identity* was influenced by R/AS families' ability to have needs met, but also by *Loss & Longing* and *Connection & Disconnect*. These themes appear to encompass R/AS young people and families experiences of adjustment to resettling in Edinburgh.

STUDY OBJECTIVES

OBJECTIVES

Primary Objective

Explore the experiences of resettlement in Scotland by young refugees and their families within the context of mental health, unmet need and service provision

Secondary Objectives

Explore the experiences of staff in Health & Social Care services working with refugee children and their families

STUDY DESIGN

This is a qualitative study using individual and group interviews to gain information about resettlement experiences for young people with refugee/ asylum seeker status in Scotland. Secondary information will be taken from the young person's family members and professional support team to gain a full understanding of the effects of resettlement on mental health. The study will also aim to get information about health and social care services for young people, from the perspectives of the young person, their family and the professionals involved in their care.

Recruitment and data collection will occur from multiple sites throughout NHS Lothian, local authorities (Social Services) and possible third sector organisations, such as Re-Act.

The researcher will be flexible about appointment setting and timing, in particular for clinicians working with refugee families.

It is estimated that the recruitment and data collection process for this study will last approximately 8-10 months. Transcription of the recordings will also occur during this time. Analysis of the data and optional participant feedback on analysis findings is estimated to take around 4-5 months with dissemination of findings to last approximately 2-4 months. Overall it is estimated that study duration will be approximately 19 months in total, however this may be subject to change should any unforeseen circumstances arise.

It is estimated that young person and family participants will be involved in the study for the time that it takes to gain informed consent until the conclusion of the interview. It is anticipated that this duration will last for approximately 3 weeks, to allow time for appointment arrangement and the provision of an interpreter.

To allow for the schedules of professional participants, it is anticipated that duration in the study will last approximately 4 weeks for professional participants.

Additional contact for feedback on analysis results will be optional- it is anticipated that this will increase study duration for the participant by approximately 10 months (depending on the date of informed consent and date of analysis). Figure 1 (below) outlines the procedure for participant recruitment and data collection.

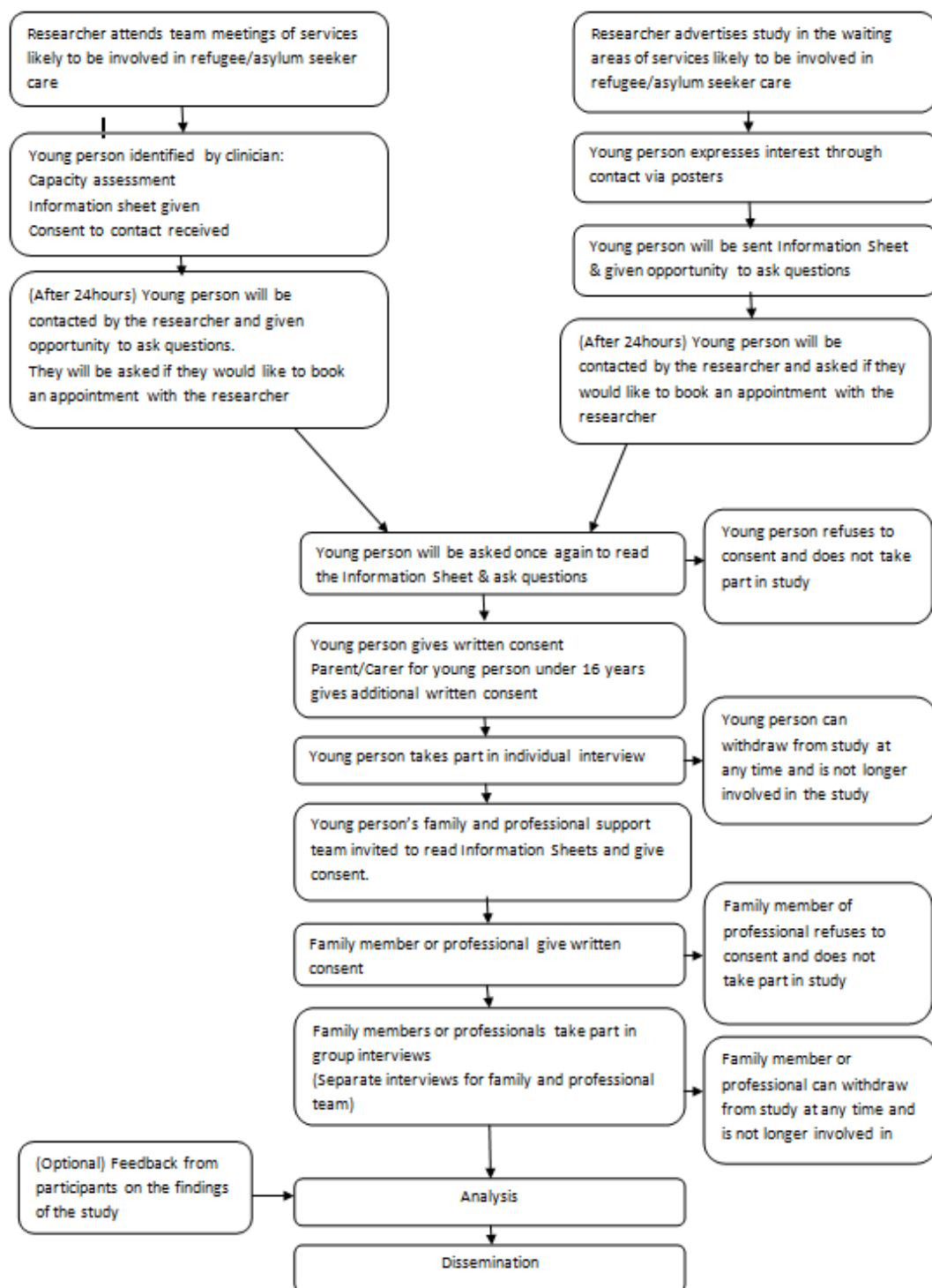


Figure 1: Study Procedure

STUDY POPULATION

NUMBER OF PARTICIPANTS

The study aims to recruit 10 refugee children/adolescents and their families for the proposed research. It is unclear how many secondary participants (family members or professional staff) will

be involved in the research as this will depend on the support system for the young person; it is anticipated that this will not exceed 100 secondary participants. .

It is estimated that the recruitment process for this study will last approximately 8-10 months. Young people will be recruited, via clinician or study posters, from various sites within NHS Lothian (e.g. CAMHS services), Social Care (e.g. LAC services) and third party organisations (e.g. Re-Act charity). Families of the young person will be invited to also participate in the research at the time of young person recruitment. Professionals working with young people will be invited to participate in group interviews.

INCLUSION CRITERIA

Young Refugees:

Children and adolescents aged 10-18 years old

Refugee status (as specified by UN Convention 1951; including those who may/may not have approved asylum status)

Young people who have applied for asylum as dependants (with their families)

Unaccompanied minors (secondary data will therefore not be collected from families)

Family:

Any family member/legal carer of the young refugee participants, living within Scotland, e.g. parents, grandparents, siblings (>10years old) etc.

Professionals:

Health and Social Care staff within Scotland, who work directly with child and adolescent refugees currently, or within the past 6 months.

EXCLUSION CRITERIA

Any participant (young people, family member or professional) with particularly acute mental health needs at the time of the study

PARTICIPANT SELECTION AND ENROLMENT

IDENTIFYING PARTICIPANTS

Young Refugee Participants: Potential child/adolescent participants will be primarily identified by their direct care team in Edinburgh, i.e. psychologists, social workers, LAC nurses, etc. Refugee/asylum seeking status will be confirmed via care records or by clinicians speaking with potential participants. Clinicians will be asked to assess the capacity of potential participants to consent to the study.

Refugee Family Participation: The family of the participating young person will be invited to speak to the researcher and answer additional questions about their experiences in Scotland.

Professional Participants: Those working with young refugees will be approached by the researcher and asked to participate in the study (with the obtained written consent of the young person and their family).

Recruitment for All Participants: Posters will also be displayed in several locations such as CAMHS out-patient clinics, reception areas of local authority offices and at the premises of voluntary refugee organisations. Contact details of the researcher will be provided for potential participants to text, phone or email with their interest in participating.

CONSENTING PARTICIPANTS

All potential participants will be asked to read the participant information sheet, adapted for age and language ability, i.e. English as a second language. Participants will be offered the option of receiving the information sheet in the language of their choice (if not already provided). Participants will also be invited to access the study videos which will explain the study aims and demands of participation.

All participants will be informed that participation in this study is entirely voluntary and refusal to participate will have no effect on care received. Participants will be able to withdraw from the study at any time, and the researchers will not put pressure on any individual to participate. Potential participants who not wish to consent to the study will be given the researchers contact details, if they wish to reconsider in the future.

Young Person: Potential participants identified through their direct care team will first be approached by a clinician known to them. This clinician will introduce the study to them and young people will be given an information leaflet to read and share with their parents/carers before consent is given for the researcher to contact. Direct care clinicians will also assess the individual's capacity to understand and consent to participation. Clinicians will gain consent-to-contact from the participant before the researcher is given any details about the individual.

Once consent for contact has been given, the researcher will wait a minimum of 24 hours before contacting the potential participant to answer any questions, identify need for interpreters and invite the potential participant to an appointment at their convenience.

This appointment will be used to discuss the information sheet, confidentiality, right to withdrawal and obtain written consent for participation. Informed consent will be obtained from primary participants (and their parents for young people aged below 16 years old). Participants will be asked for consent to contact a family member, support worker, GP or other appropriate person if the researcher feels there may be risk to themselves or to others. If consent is given, the participant will be asked if they would be happy to continue to the interview at that time, or whether they would like to book another appointment for the interview.

Families: Families of the young person will be invited to also participate in the research at the time of young person recruitment. This contact will be conducted by the researcher at least 24 hours after consent-to-contact has been given.

Professional Participants: The researcher will contact identified services and ask to attend a team meeting, leaving information sheets and contact details for team members to discuss whether they would like to participate in the study. The researcher will wait two weeks before contacting the team again to determine whether any staff would like to talk about their experiences.

Participants recruited through advertisements, i.e. posters, leaflets or via websites will be asked to contact the researcher directly, via text, phone call or email. The researcher will then return this contact and provide the necessary information sheets and consent forms to consider before participation. Participants identified through advertisements will be assessed for capacity by the Chief Investigator, using clinical judgement.

Withdrawal of Study Participants

Participants are free to withdraw from the study at any point or a participant can be withdrawn by the Investigator. If withdrawal occurs, the primary reason for withdrawal will be documented in the participant's case report form, if possible. The participant will have the option of withdrawal from

(i) all aspects of the trial but continued use of data collected up to that point

(ii) all aspects of the trial with removal of all previously collected data.

(iii) all aspects of the trial with removal of previously collected and stored participant samples.

Participants may be removed from the study if it is deemed (by the researcher or participant) that the interview is causing undue distress during the interview. It is anticipated that the risk of occurrence is low.

STUDY ASSESSMENTS

STUDY ASSESSMENTS

It is anticipated that participants will attend one appointment only, where all relevant data will be collected. It is estimated that the full procedure will last approximately one hour for each participant.

(10mins) Demographic information will be collected from refugee participants, e.g. age, gender, educational/occupational status and ethnicity.

(60mins) Interviews & Focus Groups

Interviews will be audio recorded on an encrypted recorder, and transcribed with the assistance of interpreters, if needed.

Young Refugees: Individual interviews will be conducted with each young person. Interviews will be conducted alone with the young person, unless otherwise requested by the participant. Participants will have the option of requesting another adult to join the interview, e.g. parent/carer, interpreter or other member of staff. The young person's wishes will be respected and parents/carers will be asked to wait nearby if the interview is to be conducted alone. Questions will broadly review the participant's experiences of resettlement before narrowing into the topic of mental health within the context of these experiences.

Refugee Families: Families will be invited to a focus group would to share their experiences, understanding of service provision in Scotland and potential additional needs. Focus groups may consist of one whole family, or split into groups of mothers, fathers or siblings. Group members may feel uncomfortable sharing certain information with the whole group; therefore each group member will also be given the opportunity to speak with the researcher individually.

Clinicians: Focus groups will be used to allow clinicians to express their perceptions of working with young refugees and their families. The researcher aims to invite all staff members working closely with a young person to a separate focus group. If necessary, staff may be asked to provide written

answers to the stated questions in their own time. This responsive approach aims to encourage participant recruitment and continuous engagement. The nature of questions will be tailored to the general refugee population, if the young person does not give consent to speak to caseworker.

(Optional: 30mins) Participants may be contacted via a provided telephone number or email address for further clarification and dissemination of findings.

DATA COLLECTION

Data collection will consist of transcribed interviews outlined above. All interviews and focus groups will be conducted and transcribed by the Chief Investigator.

Source Data Documentation

Source	Data
Consent Form	Participant's written consent Participant's contact details Participant's GP and Named Person details
Background Information Sheet	Participant's demographic information (Optional) Details of participant involvement with services
Audio Recording on NHS Audio Recorder	Recording of participant's interview/focus group
Recording Scripts	Transcription of participant's audio recording (anonymised)

STATISTICS AND DATA ANALYSIS

SAMPLE SIZE CALCULATION

Information from the Scottish Refugee Council was used to identify possible sample size, as an estimated number of refugee minors available for potential recruitment. In 2016, the number of applications in the UK has been estimated at 12,641 for young refugees, both as unaccompanied and dependants (Home Office, 2018). An estimated 2,012 applications for young refugees were granted asylum in the UK in 2017 (Home Office, 2018). It is suggested that 40% of recent refugees are currently living in Scotland; an estimate of 804 young refugees (Home Office, 2018; Scottish Refugee Council, 2017). A systematic review of response rates within refugee research indicated variation between studies; mental health research indicated a 41-97.1% response rate. Research exploring mental health in refugee populations indicates that recruitment difficulties may arise from stigma, cultural sensitivities, religious beliefs etc. (Schweitzer et al., 2008; Ali et al., 2017). It is therefore unclear as to an estimated response rate, however significant measure will be taken to encourage potential participants (Enticott et al., 2017).

Research into Interpretative Phenomenological Analysis (IPA; selected method for analysis) sample size indicates that an estimated 6-8 participants would be sufficient to glean detailed data (Pietkiewicz & Smith, 2014), whilst most research using IPA analysis indicates a maximum number of

15 cases. The small number of participants (with additional information from secondary sources) will allow the researched to complete detailed individual case studies, ensuring the quality of information gathered, accounting for limited time and population resources. All efforts will be taken to encourage maximum participant engagement by using a responsive design and potentially multiple methodology for data collection.

PROPOSED ANALYSES

Demographic information from participants will be collected and simple statistical analysis will be performed, e.g. mean age of participant.

Interpretative Phenomenological Analysis (IPA; Smith, Jarman & Osborn, 1999) will be used to analyse data collected from each participant group. It was determined that IPA would be the most appropriate methodology to reach the objectives of the study; the key principle of IPA is not to test specific hypotheses, but to allow an open exploration of unique lived experiences (Smith et al., 2008; Schweitzer et al., 2008).

Steps outlined by Smith & Osborn (2004) will be used to analyse the data using IPA principles. Interviews will be anonymised and transcribed verbatim (and will be independently checked for accuracy, as IPA relies heavily on the details and language used). Transcripts will be coded in detail to identify a participant's interpretation and perception of events experiences. The researcher will keep a reflective diary to acknowledge their own underlying preconceptions and attempt to suspend these from the interpretation of data.

- Transcripts will be read and re-read by researcher individually.
- The researcher will note personal observations and thoughts in left margin.
- Themes in each transcript will be written in the right margin.
- Potential common themes will be grouped together and examined for connections between themes. These will be traced to relevant quotes to ensure evidenced based themes.
- Themes which are not backed up by transcripts will be omitted.
- Shared themes will then be identified from all transcripts, to ascertain shared/common experiences by each participant group.
- This process will be overseen by the academic and clinical supervisors in order to enhance validity of results.

Interviews from young people will be analysed together, followed by separate analysis of family groups and finally professional focus groups. Transcripts from each family and support team will then be analysed together before comparison between groups in the wider framework of the study, i.e.

1. Young Person Transcripts
2. Family Transcripts
3. Staff Transcripts
4. Young Person 1, Family 1, Staff 1 Transcript
5. Young Person 2, Family 2, Staff 2 Transcript

7. Comparison of All Groups

The researcher will include participants in the analysis of the data, to improve the validity of the findings and allow participants to ensure their voice is appropriately represented.

POSSIBLE RISKS

If participants show a high level of distress during interviews or focus groups, questioning will cease immediately and the participant will be advised of their options for continuing in the study or withdrawal (with no adverse effects). If it is deemed that a high number of participants become distressed throughout interviews, the further continuation of the study will be reviewed by the Chief Investigator and other researchers.

OVERSIGHT ARRANGEMENTS

INSPECTION OF RECORDS

Investigators and institutions involved in the study will permit trial related monitoring and audits on behalf of the sponsor, REC review, and regulatory inspection(s). In the event of audit or monitoring, the Investigator agrees to allow the representatives of the sponsor direct access to all study records and source documentation. In the event of regulatory inspection, the Investigator agrees to allow inspectors direct access to all study records and source documentation.

RISK ASSESSMENT

A study specific risk assessment will be performed by representatives of the co-sponsors, ACCORD monitors and the QA group, in accordance with ACCORD governance and sponsorship SOPs. Input will be sought from the Chief Investigator or designee. The outcomes of the risk assessment will form the basis of the monitoring plans and audit plans. The risk assessment outcomes will also indicate which risk adaptations (delete if no adaptations were possible) could be incorporated into to trial design.

STUDY MONITORING AND AUDIT

The ACCORD Sponsor Representative will assess the study to determine if an independent risk assessment is required. If required, the independent risk assessment will be carried out by the ACCORD Quality Assurance Group to determine if an audit should be performed before/during/after the study and, if so, at what frequency.

Risk assessment, if required, will determine if audit by the ACCORD QA group is required. Should audit be required, details will be captured in an audit plan. Audit of Investigator sites, study management activities and study collaborative units, facilities and 3rd parties may be performed.

GOOD CLINICAL PRACTICE

ETHICAL CONDUCT

The study will be conducted in accordance with the principles of the International Conference on Harmonisation Tripartite Guideline for Good Clinical Practice (ICH GCP).

Before the study can commence, all required approvals will be obtained and any conditions of approvals will be met.

INVESTIGATOR RESPONSIBILITIES

The Investigator is responsible for the overall conduct of the study at the site and compliance with the protocol and any protocol amendments. In accordance with the principles of ICH GCP, the following areas listed in this section are also the responsibility of the Investigator. Responsibilities may be delegated to an appropriate member of study site staff.

Informed Consent

The Investigator is responsible for ensuring informed consent is obtained before any protocol specific procedures are carried out. The decision of a participant to participate in clinical research is voluntary and should be based on a clear understanding of what is involved.

Participants must receive adequate oral and written information – appropriate Participant Information and Informed Consent Forms will be provided. The oral explanation to the participant will be performed by the Investigator or qualified delegated person, and must cover all the elements specified in the Participant Information Sheet and Consent Form.

The participant must be given every opportunity to clarify any points they do not understand and, if necessary, ask for more information. The participant must be given sufficient time to consider the information provided. It should be emphasised that the participant may withdraw their consent to participate at any time without loss of benefits to which they otherwise would be entitled.

The participant will be informed and agree to their medical records being inspected by regulatory authorities and representatives of the sponsor(s).

The Investigator or delegated member of the trial team and the participant will sign and date the Informed Consent Form(s) to confirm that consent has been obtained. The participant will receive a copy of this document and a copy filed in the Investigator Site File (ISF) and participant's medical notes (if applicable).

Study Site Staff

The Investigator must be familiar with the protocol and the study requirements. It is the Investigator's responsibility to ensure that all staff assisting with the study are adequately informed about the protocol and their trial related duties.

Investigator Documentation

The Principal Investigator will ensure that the required documentation is available in local Investigator Site files ISFs.

GCP Training

For non-CTIMP (i.e. non-drug) studies all researchers are encouraged to undertake GCP training in order to understand the principles of GCP. However, this is not a mandatory requirement unless deemed so by the sponsor. GCP training status for all investigators should be indicated in their respective CVs.

Confidentiality

All laboratory specimens, evaluation forms, reports, and other records must be identified in a manner designed to maintain participant confidentiality. All records must be kept in a secure storage area with limited access. Clinical information will not be released without the written permission of the participant. The Investigator and study site staff involved with this study may not disclose or use for any purpose other than performance of the study, any data, record, or other

unpublished, confidential information disclosed to those individuals for the purpose of the study. Prior written agreement from the sponsor or its designee must be obtained for the disclosure of any said confidential information to other parties.

Data Protection

All Investigators and study site staff involved with this study must comply with the requirements of the Data Protection Act 2018 with regard to the collection, storage, processing and disclosure of personal information and will uphold the Act's core principles. Access to collated participant data will be restricted to individuals from the research team treating the participants, representatives of the sponsor(s) and representatives of regulatory authorities.

Computers used to collate the data will have limited access measures via user names and passwords.

Published results will not contain any personal data that could allow identification of individual participants.

STUDY CONDUCT RESPONSIBILITIES

PROTOCOL AMENDMENTS

Any changes in research activity, except those necessary to remove an apparent, immediate hazard to the participant in the case of an urgent safety measure, must be reviewed and approved by the Chief Investigator.

Amendments will be submitted to a sponsor representative for review and authorisation before being submitted in writing to the appropriate REC, and local R&D for approval prior to participants being enrolled into an amended protocol.

MANAGEMENT OF PROTOCOL NON COMPLIANCE

Prospective protocol deviations, i.e. protocol waivers, will not be approved by the sponsors and therefore will not be implemented, except where necessary to eliminate an immediate hazard to study participants. If this necessitates a subsequent protocol amendment, this should be submitted to the REC, and local R&D for review and approval if appropriate.

Protocol deviations will be recorded in a protocol deviation log and logs will be submitted to the sponsors every 3 months. Each protocol violation will be reported to the sponsor within 3 days of becoming aware of the violation. All protocol deviation logs and violation forms should be emailed to QA@accord.scot

Deviations and violations are non-compliance events discovered after the event has occurred. Deviation logs will be maintained for each site in multi-centre studies. An alternative frequency of deviation log submission to the sponsors may be agreed in writing with the sponsors.

SERIOUS BREACH REQUIREMENTS

A serious breach is a breach which is likely to effect to a significant degree:

- (a) the safety or physical or mental integrity of the participants of the trial; or
- (b) the scientific value of the trial.

If a potential serious breach is identified by the Chief investigator, Principal Investigator or delegates, the co-sponsors (seriousbreach@accord.scot) must be notified within 24 hours. It is the

responsibility of the co-sponsors to assess the impact of the breach on the scientific value of the trial, to determine whether the incident constitutes a serious breach and report to research ethics committees as necessary.

STUDY RECORD RETENTION

All study documentation will be kept for a minimum of 3 years from the protocol defined end of study point. When the minimum retention period has elapsed, study documentation will not be destroyed without permission from the sponsor.

END OF STUDY

The end of study is defined as the last participant's last visit.

The Investigators or the co-sponsor(s) have the right at any time to terminate the study for clinical or administrative reasons.

The end of the study will be reported to the REC, and R+D Office(s) and co-sponsors within 90 days, or 15 days if the study is terminated prematurely. The Investigators will inform participants of the premature study closure and ensure that the appropriate follow up is arranged for all participants involved. End of study notification will be reported to the co-sponsors via email to resgov@accord.scot.

A summary report of the study will be provided to the REC within 1 year of the end of the study.

INSURANCE AND INDEMNITY

The co-sponsors are responsible for ensuring proper provision has been made for insurance or indemnity to cover their liability and the liability of the Chief Investigator and staff.

The following arrangements are in place to fulfil the co-sponsors' responsibilities:

The Protocol has been designed by the Chief Investigator and researchers employed by the University and collaborators. The University has insurance in place (which includes no-fault compensation) for negligent harm caused by poor protocol design by the Chief Investigator and researchers employed by the University.

Sites participating in the study will be liable for clinical negligence and other negligent harm to individuals taking part in the study and covered by the duty of care owed to them by the sites concerned. The co-sponsors require individual sites participating in the study to arrange for their own insurance or indemnity in respect of these liabilities.

Sites which are part of the United Kingdom's National Health Service will have the benefit of NHS Indemnity.

Sites out with the United Kingdom will be responsible for arranging their own indemnity or insurance for their participation in the study, as well as for compliance with local law applicable to their participation in the study.

REPORTING, PUBLICATIONS AND NOTIFICATION OF RESULTS

AUTHORSHIP POLICY

Ownership of the data arising from this study resides with the study team.